AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

PRESCRIPTION DRUG ABUSE EPIDEMIC IN AMERICA

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

MARCH 7, 2012

Serial No. 112–95

Printed for the use of the Committee on the Judiciary

Available via the World Wide Web: http://judiciary.house.gov

U.S. GOVERNMENT PRINTING OFFICE
73–212 PDF WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON THE JUDICIARY

LAMAR SMITH, Texas, *Chairman*

F. JAMES SENSENBRENNER, JR., Wisconsin
HOWARD COBLE, North Carolina
ELTON GALLEGLY, California
BOB GOODLATTE, Virginia
DANIEL E. LUNGREN, California
STEVE CHABOT, Ohio
DARRELL E. ISSA, California
MIKE PENCE, Indiana
J. RANDY FORBES, Virginia
STEVE KING, Iowa
TRENT FRANKS, Arizona
LOUIE GOHMERT, Texas
JIM JORDAN, Ohio
TED POE, Texas
JASON CHAFFETZ, Utah
TIM GRIFFIN, Arkansas
TOM MARINO, Pennsylvania
TREY GOWDY, South Carolina
DENNIS ROSS, Florida
SANDY ADAMS, Florida
BEN QUAYLE, Arizona
MARK AMODEI, Nevada

JOHN CONYERS, JR., Michigan
HOWARD L. BERMAN, California
JERROLD NADLER, New York
ROBERT C. "BOBBY" SCOTT, Virginia
MELVIN L. WATT, North Carolina
ZOE LOFGREN, California
SHEILA JACKSON LEE, Texas
MAXINE WATERS, California
STEVE COHEN, Tennessee
HENRY C. "HANK" JOHNSON, JR., Georgia
PEDRO R. PIERLUISI, Puerto Rico
MIKE QUIGLEY, Illinois
JUDY CHU, California
TED DEUTCH, Florida
LINDA T. SÁNCHEZ, California
JARED POLIS, Colorado

RICHARD HERTLING, *Staff Director and Chief Counsel*
PERRY APELBAUM, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

F. JAMES SENSENBRENNER, JR., Wisconsin, *Chairman*
LOUIE GOHMERT, Texas, *Vice-Chairman*

BOB GOODLATTE, Virginia
DANIEL E. LUNGREN, California
J. RANDY FORBES, Virginia
TED POE, Texas
JASON CHAFFETZ, Utah
TIM GRIFFIN, Arkansas
TOM MARINO, Pennsylvania
TREY GOWDY, South Carolina
SANDY ADAMS, Florida
MARK AMODEI, Nevada

ROBERT C. "BOBBY" SCOTT, Virginia
STEVE COHEN, Tennessee
HENRY C. "HANK" JOHNSON, JR., Georgia
PEDRO R. PIERLUISI, Puerto Rico
JUDY CHU, California
TED DEUTCH, Florida
SHEILA JACKSON LEE, Texas
MIKE QUIGLEY, Illinois
JARED POLIS, Colorado

CAROLINE LYNCH, *Chief Counsel*
BOBBY VASSAR, *Minority Counsel*

CONTENTS

MARCH 7, 2012

Page

OPENING STATEMENTS

The Honorable F. James Sensenbrenner, Jr., a Representative in Congress from the State of Wisconsin, and Chairman, Subcommittee on Crime, Terrorism, and Homeland Security 1
The Honorable Robert C. "Bobby" Scott, a Representative in Congress from the State of Virginia, and Ranking Member, Subcommittee on Crime, Terrorism, and Homeland Security 2

WITNESSES

The Honorable Harold Rogers, a Representative in Congress from the State of Kentucky
Oral Testimony 11
Prepared Statement 13
The Honorable Nick J. Rahall, II, a Representative in Congress from the State of West Virginia
Oral Testimony 18
Prepared Statement 20
The Honorable Mary Bono Mack, a Representative in Congress from the State of California
Oral Testimony 22
Prepared Statement 24
The Honorable Stephen F. Lynch, a Representative in Congress from the State of Massachusetts
Oral Testimony 27
Prepared Statement 29

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

NIH Public Access Study on Opiod Deaths in Rual Virginia 45
Prepared Statement of Ameritox, Inc. 65
Prepared Statement of Anne McGee, Director, Cabell County Substance Abuse Prevention Partnership 68
Prepared Statement of Greg Puckett, Executive Director, Community Connections, Inc. 70
Prepared Statement of Timothy Bradley, Captain, West Virginia State Police . 85
Prepared Statement of Kimberly Becher, MD; and Kane Maiers, MD, Paul Ambrose Health Policy Fellows, Marshall University Department of Family and Community Health 88

PRESCRIPTION DRUG ABUSE EPIDEMIC IN AMERICA

WEDNESDAY, MARCH 7, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIME, TERRORISM,
AND HOMELAND SECURITY,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:02 a.m., in room 2141, Rayburn Office Building, the Honorable F. James Sensenbrenner, Jr., (Chairman of the Subcommittee) presiding.

Present: Representatives Sensenbrenner, Goodlatte, Marino, Gowdy, Adams, Conyers, Scott, and Jackson Lee.

Staff present: Caroline Lynch, Majority Chief Counsel; Arthur Radford Baker and Tony Angeli, Majority Counsel; Ron LeGrand and Ashley McDonald, Minority Counsel; Lindsay Hamilton, Clerk; and Veronica Eligan.

Mr. SENSENBRENNER. The Subcommittee on Crime will come to order. Without objection, the Chair will be authorized to declare recesses during votes in the House.

The Chair yields himself 5 minutes, in order to make an opening statement.

Today's hearing examines the subject of prescription drug abuse in America. According to the most recent data from the U.S. Centers for Disease Control and Prevention, legal and illicit drugs killed almost 40,000 people nationwide in 2009. Over 100 people die from drug overdoses in the United States every day.

Nearly 3 out of 4 prescription drug overdoses are caused by prescription painkillers, also called opioid pain relievers. Common examples of these painkillers are Vicodin, Percocet, OxyContin, and Demerol.

In 2008, there were nearly 15,000 deaths from prescription painkiller overdoses. For every one of these deaths, there are 10 admissions for drug abuse treatment, and 32 emergency room visits for misuse or abuse of prescription drugs. That amounts to over 475,000 emergency room visits per year, a number which has doubled in just the last 5 years.

Prescription painkillers work by decreasing the perception of pain. These powerful drugs can create feelings of euphoria, cause physical dependence, and frequently lead to addiction. Prescription painkillers also slow down a person's breathing. A person abusing prescription painkillers might take increasingly larger doses to achieve a euphoric effect. These larger doses can cause breathing

to slow down so much that breathing stops, resulting in a fatal overdose.

Very few prescription drugs involved in overdoses come from pharmacy theft. The vast majority come from physicians' prescriptions obtained by one person and sold or given to another. More than 3 out of 4 people who misuse prescription painkillers get their drugs from someone else. For the past few years, individuals who doctor shop, or seek care from multiple physicians, but fraudulently pretend to be in pain, have been a primary source of diverted prescription drugs.

The law enforcement officials in Florida, once the epicenter of prescription drug diversion, have left other States to initiate expensive enforcement programs, as the so-called pill mills migrate across the country.

Prescription drug abuse has been an epidemic for much too long. Some of the more notable people who have died from prescription drugs include Marilyn Monroe, Bruce Lee, and Elvis Presley. Even former Indiana Senator Edward A. Hannegan overdosed on morphine in 1859. In December of 2010, a 13-year-old Utah boy died after stealing a bottle of OxyContin from a kitchen counter of a friend's house. He took all the pills in the bottle, except one, and died in his sleep. Famous or not, no one is immune from the grip of prescription drug overdose.

This hearing will explore the growing issue of prescription drug abuse in our Nation. We have here today four distinguished Members of Congress, who have dedicated their efforts to stop prescription abuse in America. I look forward to hearing about their legislative proposals and other efforts to address a serious national challenge. And I would like to thank our witnesses for participating in today's hearing.

It is now my pleasure to recognize for his opening statement, the Ranking Member of the Subcommittee, the gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman. Mr. Chairman, prescription drug abuse is a serious problem. The number of overdose fatalities has increased dramatically over the recent years. I must admit, though, Mr. Chairman, I am puzzled as to the purpose and usefulness of today's hearing. I am used to hearings being an opportunity for witnesses to put forth varying views regarding an issue or issues before us, with the opportunity to question such witnesses to gain a keener insight and understanding of the issues.

We would then have a legislative hearing for further input and analysis, including legal analysis, and ensuring that we have constitutional and effective legislation. While I have no doubt that our colleagues who are witnesses today will provide helpful information, I anticipate that they will discuss the bills that they have sponsored or cosponsored, which makes them advocates for the bills, and limits us to one side of the debate on the issues raised by those bills.

Therefore, I trust and also ask that this hearing not serve as the only basis for any Judiciary Committee or other consideration of legislation that we will hear about, but merely serve as a traditional opportunity we give Members, on occasion, to appear before us to present their legislation.

The bills I anticipate my colleagues will discuss as witnesses include H.R. 1316, 1065, 1925, and 2119. To the extent that they provide additional education, training, and research on safer administration and use of prescription drugs, I am inclined to believe that they may contribute to effectively addressing the problem. However, to the extent that they impose congressionally mandated restrictions on access to legitimate medications and business-as-usual draconian increases in Federal penalties, I am inclined to believe that they will be counterproductive.

Such approach is not likely to be successful, as our efforts to effectively address elicit drugs. They will lead to over criminalization, over federalization, and cause many people the laws purport to protect to end up with unjust and inflexible prison terms, such as the mandatory minimums, which one of the bills calls for.

Mandatory minimums have been proven to be a waste of the taxpayers' money, and violate common sense, when compared to traditional sentencing. And I would ask unanimous consent, Mr. Chairman, to introduce the Rand study that points this out.

Mr. SENSENBRENNER. Without objection.

[The information referred to follows:]

RAND OBJECTIVE ANALYSIS. EFFECTIVE SOLUTIONS.

Are Mandatory Minimum Drug Sentences Cost-Effective?

Are Mandatory Minimum Drug Sentences Cost-Effective?

Mandatory minimum sentencing laws have been among the more popular crime-fighting measures of recent years. Such laws require that a judge impose a sentence of at least a specified length if certain criteria are met. For example, a person convicted by a federal court of possessing half a kilogram or more of cocaine powder must be sentenced to at least five years in prison.

Mandatory minimums have enjoyed strong bipartisan support. To proponents, their certainty and severity help ensure that incarceration's goals will be achieved. Those goals include punishing the convicted and keeping them from committing more crimes for a period of time, as well as deterring others not in prison from committing similar crimes. Critics, however, believe that mandatory minimums foreclose discretionary judgment where it may most be needed, and they fear these laws result in instances of unjust punishment.

These are all important considerations, but mandatory minimums associated with drug crimes may also be viewed as a means of achieving the nation's drug control objectives. As such, how do they compare with other means? Do they contribute to the central objective--decreasing the nation's drug consumption and related consequences--at a cost that compares favorably with other approaches? Jonathan P. Caulkins, C. Peter Rydell, William L. Schwabe, and James Chiesa have estimated how successful mandatory minimum sentences are, relative to other control strategies, at reducing drug consumption and drug-related crime.

The DPRC researchers focused on cocaine, which many view as the most problematic drug in America today. They took two approaches to mathematically model the market for cocaine and arrived at the same basic conclusion: *Mandatory minimum sentences are not justifiable on the basis of cost-effectiveness at reducing cocaine consumption or drug-related crime.* Mandatory minimums reduce cocaine consumption less per million taxpayer dollars spent than spending the same amount on enforcement under the previous sentencing regime. And either enforcement approach reduces drug consumption less, per million dollars spent, than putting heavy users through treatment programs. Mandatory minimums are also less cost-effective than either alternative at reducing cocaine-related crime. A principal reason for these findings is the high cost of incarceration.

Reducing Consumption: More Enforcement Against Typical Dealers

Caulkins, Rydell, and their colleagues first estimated the cost-effectiveness of additional expenditures on enforcement against the average drug dealer apprehended in the United States (whether that apprehension is by federal, state, or local authorities). Increased enforcement places additional costs on dealers, which they pass along to cocaine consumers in the form of higher prices. Studies have shown that higher cocaine prices discourage consumption. By mathematically modeling how cocaine market demand and supply respond to price, the researchers were able to estimate the changes in total cocaine consumption over 15 years for an additional million dollars invested in different cocaine control strategies. These consumption changes, discounted to present value, are shown by the first two bars in Figure 1.

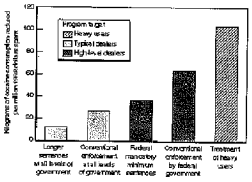


Figure 1--Cost-Effectiveness of Alternative Cocaine Control Strategies

Those bars show the results of spending a million dollars[1] on additional enforcement against a representative sample of drug dealers. As shown by the first bar, if that money were used to extend to federal mandatory minimum lengths the sentences of dealers who would have been arrested anyway, U.S. cocaine consumption would be reduced by almost 13 kilograms.[2] If, however, the money were used to arrest, confiscate the assets of, prosecute, and incarcerate more dealers (for prison terms of conventional length), cocaine consumption would be reduced by over 27 kilograms. As a point of comparison, spending the million dollars to treat heavy users would reduce cocaine consumption by a little over 100 kilograms (rightmost bar).

The results from spending an additional million dollars can be extrapolated to multiples thereof. A case can thus be made for shifting resources from longer sentences to a broader mix of enforcement measures. A case might also be made for shifting resources to treatment, although legislators might find such a shift less palatable. In any event, extrapolation is valid only up to a point. These results certainly do not support shifting all drug control resources from one approach to another, e.g., from enforcement to treatment. Very large changes in enforcement levels or in the number of persons treated would change cocaine supply and demand relations in ways that are not predictable with much confidence.

Reducing Consumption: More Enforcement Against Higher-Level Dealers

The first two bars in Figure 1 represent enforcement approaches applied to a representative sample of drug dealers. Perhaps mandatory minimum sentences would be more cost-effective if they were applied only to higher-level dealers, who make more money and thus have more to lose from intensive enforcement. To approximate such a restriction, Caulkins and his colleagues limited the set of dealers analyzed to those prosecuted at the federal level who possess enough drugs to trigger a federal mandatory minimum sentence. Again, they analyzed how costs imposed on dealers influence cocaine market demand and supply. The results are shown in the dark bars in Figure 1.

Spending a million dollars on mandatory minimum sentences for higher-level dealers does indeed have a bigger effect on cocaine consumption than spending the same amount on either enforcement approach against typical dealers. Nonetheless, against any given type of dealer (or at any given level of government), mandatory minimums are less cost-effective than conventional enforcement. Moreover, although federal mandatory minimums do better relative to treating heavy users than do longer sentences for all dealers, treatment is still more cost-effective.

Why is conventional enforcement more cost-effective than mandatory minimums? Drug enforcement imposes costs on dealers through arrest and conviction, which includes seizure of drugs and other assets, and through incarceration, which involves loss of income. It turns out that, *per dollar spent*, the cost burden from seizures is greater. A million dollars spent extending sentences thus imposes less cost on dealers--and consequently reduces cocaine consumption less--than a million dollars spent on conventional enforcement, which includes asset seizures.[3]

Reducing Cocaine-Related Crime

Many Americans are worried about the crime associated with cocaine production, distribution, and use. Working with data on the causes of drug-related crime, Caulkins and his colleagues estimated the crime reduction benefits of the various alternatives. They found no difference between conventional enforcement and mandatory minimums in relation to property crime. Conventional enforcement, however, should reduce crimes against persons by about 70 percent more than mandatory minimums. But treatment should reduce serious crimes (against both property and persons) the most per million dollars spent--on the order of fifteen times as much as would the incarceration alternatives.

Why is treatment so much better? Most drug-related crime is economically motivated--undertaken, for example, to procure money to support a habit or to settle scores between rival dealers. The level of economically motivated crime is related to the amount of money flowing through the cocaine market. When a treated dealer stays off drugs, that means less money flowing into the market--therefore, less crime. When a dealer facing greater enforcement pressure raises his price to compensate for the increased risk, buyers will reduce the amount of cocaine they purchase. Money flow equals price times quantity bought. Which effect predominates--the rise in price or the drop in consumption? The best evidence suggests that they cancel each other out, so the total revenue flowing through the cocaine market stays about the same. The effect of the enforcement alternatives is therefore limited almost entirely to the relatively small number of crimes that are the direct result of drug consumption--crimes "under the influence."

Sensitivity of the Results to Changes in Assumptions

The values shown in Figure 1 are dependent, of course, on various assumptions the researchers made. If the assumptions are changed, the values change. As an example, the results are dependent on the time horizon of interest to those making decisions about cocaine control strategy. Figure 1, for example, ignores any benefits and costs accruing more than 15 years beyond program initiation. A 15-year horizon is a typical one for analyzing public-policy effects. But what if that horizon were closer?

Figure 2 shows the relative cost-effectiveness of treatment and the enforcement alternatives against typical dealers, analyzed when time horizons are set at various points from 1 to 15 years. At 15 years, the lines match the heights of the two short bars and the tallest bar in Figure 1. As the horizon is shortened, treatment looks worse, because treatment's costs, which accrue immediately, remain, while the benefits, which accrue as long as treated individuals reduce their consumption, are cut back. If the horizon is made short enough, long sentences look better, because the costs of additional years of imprisonment are ignored, while the benefits remain. Those benefits, again, are the cocaine price increase and consumption decrease that occur as soon as the imprisonment risk increases. The time horizon must be shortened to three years before long sentences look preferable to additional conventional enforcement, and to little more than two years before they look preferable to treatment. Hence, longer sentences for typical drug dealers appear cost-effective only to the highly myopic.

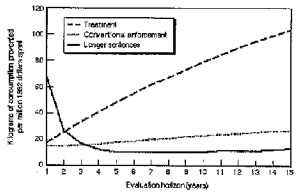


Figure 2--Cost-Effectiveness of Treating Heavy Users and Enforcement Against Typical Drug Dealers, for Different Evaluation Horizons

More generally, large departures from the assumptions underlying the analysis are required for mandatory minimums to be the most cost-effective approach. Figure 3, for example, displays departures from two key assumptions underlying the results in Figure 1: that it costs the federal government $20,000 to arrest a dealer and that a dealer wants additional drug sales income amounting to $85,000 for risking an additional year of imprisonment. These two assumed values are depicted by the star in Figure 3. The bounded areas and labels indicate which program is the most cost-effective for any combination of substitutes for those two numbers. As the figure shows, mandatory minimums would be the most cost-effective alternative only if arrest cost were to exceed $30,000 and a dealer were to value his time at over $250,000 per year. Such figures would typify only those dealers who are both unusually difficult to arrest and at a fairly high level in the cocaine trade. For dealers costing less than $30,000 to arrest, cocaine control dollars would be better spent on further conventional enforcement. For dealers demanding less than $250,000 compensation for imprisonment risk, the money would be better spent treating heavy users.

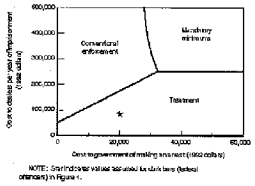


Figure 3--Most Cost-Effective Strategy for Different Combinations of Values for Two Key Variables

Long sentences could thus be a smart strategy if selectively applied. Unfortunately, because mandatory minimum sentences are triggered by quantity of drug possessed, they are not selectively applied to the highest-level dealers. Such dealers often do not physically possess the drugs they own and control; they hire others to carry the drugs and incur the associated risk.

Conclusion

Long sentences for serious crimes have intuitive appeal. They respond to deeply held beliefs about punishment for evil actions, and in many cases they ensure that, by removing a criminal from the streets, further crimes that would have been committed will not be. But in the case of black-market crimes like drug dealing, a jailed supplier is often replaced by another supplier. Limited cocaine control resources can, however, be profitably directed toward other important objectives--reducing cocaine consumption and the violence and theft that accompany the cocaine market. If those are the goals, more can be achieved by spending additional money arresting, prosecuting, and sentencing dealers to standard prison terms than by spending it sentencing fewer dealers to longer, mandatory terms. The DPRC researchers found an exception in the case of the highest-level dealers, where sentences of mandatory minimum length appear to be the most cost-effective approach. However, it is difficult to identify those dealers solely by quantity of drug possessed. It might be easier to identify them if, in passing sentence, the criminal justice system could consider additional factors, e.g., evidence regarding a dealer's position in the distribution hierarchy. Such factors, ignored by mandatory minimums, can

be taken into account by judges working under discretionary sentencing.

[1] All cost calculations in this brief are in 1992 dollars. To convert costs in 1992 dollars to 1996 dollars (the latest year for which inflation data are available), multiply by 1.119. To convert kilograms of cocaine consumption reduced per million 1992 dollars spent to kilograms reduced per million 1996 dollars, divide by 1.119.
[2] Data on quantities possessed by convicted dealers are not readily available below the federal level, so for typical dealers, the researchers assessed, in lieu of true mandatory minimums, a program applying longer sentences to all who were convicted.

[3] As shown in earlier RAND research, treatment is more cost-effective than enforcement, even though the great majority of users revert to their cocaine habit following treatment. Treatment is so much cheaper than enforcement that many more users can be targeted for the same amount of money--so many more that the sum of the small individual effects expected are larger than the effects expected from enforcement.

RAND research briefs summarize research that has been more fully documented elsewhere. This research brief describes work sponsored, through DPRC, by Richard B. Wolf of Richland Mills and by The Ford Foundation; it is documented in *Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money?* by Jonathan P. Caulkins, C. Peter Rydell, William L. Schwabe, and James Chiesa, MR-827-DPRC, 1997, 217 pp., ISBN: 0-8330-2453-1. Abstracts of all RAND documents may be viewed on the World Wide Web (). Publications are distributed to the trade by National Book Network. RAND is a nonprofit institution that helps improve public policy through research and analysis; its publications do not necessarily reflect the opinions or policies of its research sponsors.
RB-6003 (1997)

Copyright © 1997 RAND

All rights reserved. Permission is given to duplicate this on-line document for personal use only, as long as it is unaltered and complete. Copies may not be duplicated for commercial purposes.

Published 1997 by RAND

Mr. SCOTT. When we think of a pill mill operator dispensing death and destruction on a mass scale, we may conclude that no punishment is too great, but without definition of what limits the application of such person to such circumstances, the, quote, Pill mill operator may be a college student in a dorm room, with a bunch of pills given to his dorm mates.

What has proven to work best to address drug abuse, in general, including prescription drug abuse are evidence-based solutions aimed at preventing drug abuse addiction, injury, and death, rath-

er than inflexibly rushing to increased penalties, and restrict legitimate excess to prescriptive drugs.

We should not continue to take the same approaches, hoping for different results. I am not saying that we should not punish lawmakers, but we are already using the criminal justice system as much as reductively can be used. We now need to focus on prevention and early intervention.

There are innovative evidence-based approaches that are not likely to be discussed today. One is the use of Naloxone. That is a lifesaving medicine used to reverse opiate-based drug overdoses. It has been FDA approved since 1971, and is the first line of treatment for paramedics and emergency room physicians who encounter an opiate overdose victim.

It presents no potential for abuse, because it has no pharmacological effect. It has no effect if it is taken by a person who does not have opiates in their system. It takes as little as 2 minutes to start working, and provides a 30- to 90-minute window to call for medical assistance during a drug overdose.

Drugs that can be reversed are heroin, OxyContin, methadone, Vicontin, and several other drugs. If we are concerned about drug overdose deaths, we should be considering this as one of the suggestions.

The second thing we need to consider, Mr. Chairman, are a 911 Good Samaritan law. The chance of surviving an overdose like that, of surviving a heart attack, depends greatly on how fast one receives medical treatment. Witnesses to heart attacks rarely think twice about calling 911, but witnesses to an overdose often hesitate to call, or simply don't make a call, because they fear police involvement.

People using illegal drugs often fear arrest, even in cases where they need professional and medical advice, or assistance for a friend or family member. The best way to encourage overdose witnesses to speak up and call 911 is to provide some kind of immunity to those that make such calls.

Mr. Chairman, such legislation does not protect people from arrest for other offenses, such as outstanding warrants or other crimes, but this policy protects only the caller and the overdose victim from arrest and prosecution, simply for calling 911. Several State legislatures, including New York, New Mexico, Washington, Illinois, and Connecticut have passed 911 Good Samaritan laws, and Congress should consider doing the same.

For the reasons stated above, Mr. Chairman, I agree with my colleagues that prescription drug abuse is an issue about which we should be concerned. Anyone who has a friend that is a physician or a dentist will recite patients that present with symptoms that call for these drugs, and they go doctor to doctor, shopping, and we need to do something about those who will actually prescribe to those patients. But we should not rush to enact such legislation without thorough assessment of the effective options we have before us, and I certainly do not agree that imposing more severe mandatory minimums on physicians and pharmacists, who provide legitimate medications, would be a good use of our time or efforts.

Mr. Chairman, I would ask, also, unanimous consent to enter into the record a letter to us from the Drug Policy Alliance.

Mr. SENSENBRENNER. Without objection.
[The information referred to follows:]

March 7, 2012

We are the Drug Policy Alliance.

The Honorable Jim Sensenbrenner
United States House of Representatives
Chairman, Subcommittee on Crime, Terrorism and Homeland Security
2449 Rayburn House Office Building
Washington, D.C. 20015

The Honorable Robert C. Scott
United States House of Representatives
Ranking Member, Subcommittee on Crime, Terrorism and Homeland Security
1201 Longworth House Office Building
Washington, D.C. 20015

Dear Chairman Sensenbrenner and Ranking Member Scott:

The Drug Policy Alliance is the nation's foremost organization promoting alternatives to current drug policy that are grounded in science, compassion, health and human rights. We are encouraged that the House of Representatives is taking action against the prescription drug overdose crisis that is plaguing our country – accidental drug overdose is now the number one cause of accidental death in the United States, having surpassed deaths due to motor vehicles collisions. However, we are concerned that legislative proposals under consideration by Congress will severely restrict access to opioid medications and place additional barriers between patients and the analgesic medications they need, without fully utilizing effective interventions to prevent overdose fatalities. The Drug Policy Alliance encourages the House of Representatives to consider alternative means of saving lives and to respond to the prescription drug abuse crisis in a comprehensive manner.

H.R. 1925, the Drug Abuse Prevention and Treatment Act of 2011, contains two areas of concern: banning prescribing of 40 mg methadone diskettes and granting federal law enforcement access to state prescription drug monitoring programs (PDMPs). This legislation would prohibit practitioners (other than hospitals that provide direct patient supervision) from prescribing 40-mg tablets of methadone "unless such prescription....is consistent with the current DEA methadone policy" until an HHS commission issues guidelines on dosing and finds the 40 mg tablet is "safe and clinically appropriate."

This legislation intrudes upon the doctor-patient relationship; Congress should support the ability of a physician or treatment provider to determine the best course of therapy for the patient, not undermine it. There is also concern that this provision interferes with the ability of treatment providers to meet the needs of individuals enrolled in methadone replacement therapy who have a high tolerance for opiates, and whose success in methadone treatment could be dependent upon access to the 40 mg tablet. Methadone providers already contend with extensive federal and state regulations and restrictions when providing treatment services to patients and this legislation would add yet another challenge. Providers and practitioners should have as many treatment options available to them as possible.

In addition, H.R. 1925 would require states receiving controlled substances monitoring program grants to provide information, upon request, to federal drug enforcement officials relating to an individual who is the subject of an active drug-related investigation. Prescription drug monitoring databases should be created and managed with the sole purpose of making prescribing information available to physicians and pharmacists in order to reduce medical errors and over-

Drug Policy Alliance | 925 15th Street NW, 2nd Floor, Washington, DC 20005
202.216.0035 voice | 202.216.0803 fax | www.drugpolicy.org

prescribing. These databases should not be a law enforcement centered tool, nor should law enforcement have unrestricted access to prescription drug databases, which contain deeply personal information about which medications each American is currently being prescribed.

Allowing federal law enforcement to access state PDMP data at their discretion puts additional and unnecessary scrutiny on physicians whose controlled substance prescribing practices already face scrutiny from the DEA and state licensing boards. In addition to the possibility of targeting physicians who have a large number of elderly patients or patients with chronic pain who rely on opioid analgesic medications, scrutiny by federal prosecutors may have a chilling effect on the prescribing of controlled substances by physicians who fear meddling by federal authorities.

Currently, the House of Representatives is contemplating other pieces of legislation which could further contribute to this chilling effect. H.R. 1316, the Stop Oxy Abuse Act of 2011, would force the FDA to ban the use of oxycodone (Oxy) except for severe pain instead of moderate-to-severe pain, as it is currently indicated. It is the role of the FDA – not Congress – to develop guidelines for the prescribing of opioid medications. Additionally, H.R. 1065, a bill that would amend the Controlled Substances Act to provide for increased penalties for operators of pill mills, is troubling as it fails to define what a "pill mill" is but increases penalties and forfeiture provisions for any pill mill operator. Prescription drug policies should be based on science, not punitive politics, and these bills do not meet that standard.

We encourage the House of Representatives to consider alternative methods of reducing overdose fatalities. One method of doing this is to expand access to naloxone, a life-saving medicine used to reverse opiate- and opioid-based drug overdoses. It has been FDA-approved since 1971 and is the first line of treatment for paramedics and emergency room physicians who encounter an opiate overdose victim. Naloxone presents no potential for abuse as it has no pharmacological effect other than reversing opiate and opioid overdose; it also has no effect if it is taken by a person that does not have opiates in their system. However, it needs to be made more readily available to those who may be in a position to respond to an overdose. Opiate drugs that can be reversed by naloxone include heroin, Oxycontin, methadone, vicodin, percocet, fentanyl, and morphine. Naloxone takes as little as two minutes to start working, and provides additional time to obtain necessary medical assistance during an overdose.

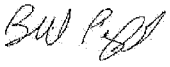
In addition to expanding the availability of naloxone, it is critical that people be trained on how to recognize and respond to an overdose and administer naloxone – greatly increasing the likelihood that a drug overdose will not result in a fatality. Concerted training efforts aimed at those at-risk of an overdose, those who reside with, interact with or care for people at-risk for a drug overdose – such as family members, health care providers, spouses, law enforcement officers and correctional officers – will allow naloxone to be used as widely and effectively as possible – saving as many lives as possible.

Like naloxone, Good Samaritan laws also work to increase the survival rate of prescription drug overdoses. The chance of surviving an overdose, as with surviving a heart attack, depends on how fast one receives medical assistance. Witnesses to heart attacks rarely think twice about calling 911, but witnesses to an overdose often hesitate to call for help or, in some cases, simply don't make the call. The most common reason people cite for not calling 911 is fear of police involvement. The best way to encourage overdose witnesses to seek medical help is to exempt them from criminal prosecution, an approach often referred to as 911 Good Samaritan laws. Such legislation does not protect people from arrest for other offenses; it only protects the overdose victim and people helping the victim from arrest and prosecution for simple drug

possession, possession of paraphernalia, and/or being under the influence. Laws encouraging overdose witnesses and victims to seek medical attention may also be accompanied by training for law enforcement, EMS and other emergency personnel. New York, New Mexico, Washington, Illinois, and Connecticut have all enacted a 911 Good Samaritan law and several states are currently considering measures.

In the 111th Congress, Congresswoman Donna F. Edwards (D-MD) introduced the Drug Overdose Reduction Act (H.R. 2855, DORA), providing Congress with a blueprint for a multi-faceted, evidence-based response to the drug overdose crisis. This comprehensive legislation dedicated federal resources to expanding and supporting overdose prevention programs in communities and improved access to naloxone. The legislation also directed federal agencies to strategically boost surveillance, research and reporting efforts aimed at better understanding the overdose crisis and where resources are needed the most. The Drug Policy Alliance encourages the House of Representatives to continue its careful deliberations on how best to reduce overdose fatalities, especially through expanding access to naloxone and implementing 911 Good Samaritan laws, as DORA laid out, but does not endorse any of the bills under consideration in this Congress listed in this letter.

Sincerely,



Bill Piper
Director, Office of National Affairs

Mr. SENSENBRENNER. It is now my pleasure to introduce today's witnesses.

Hal Rogers has represented the Fifth District of Kentucky since 1981. He currently serves as Chairman of the House Appropriations Committee, of which he has been a Member for 29 years. He

received both his bachelor of arts and LLB from the University of Kentucky.

Congressman Nick Rahall has represented the Third District of West Virginia since 1976. He currently serves as the Ranking Member of the House Transportation and Infrastructure Committee, and received his bachelor of arts from Duke University in 1971.

Mary Bono Mack has represented the 45th District of California since 1998. Ms. Bono Mack sits on the House Energy and Commerce Committee, and serves as Chairwoman of the Subcommittee on Commerce, Manufacturing, and Trade. She received her BFA from the University of Southern California in 1984.

Congressman Stephen Lynch has represented the Ninth District of Massachusetts since 2001. He currently sits on the Financial Services Committee, and the Committee on Oversight and Government Reform, where he serves as Ranking Member of the Subcommittee on Federal Workforce, U.S. Postal Service, and Labor Policy. He received his bachelor of arts degree from Wentworth Institute of Technology and his master in public administration in 1998, from Harvard.

Without objection, all of the witnesses' written statements will be entered into the record in their entirety. And I ask that you please summarize your testimony in 5 minutes or less. And we will start out with Congressman Rogers, since I kind of respect seniority.

TESTIMONY OF THE HONORABLE HAROLD ROGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. ROGERS. I thank you, Mr. Chairman. Chairman Sensenbrenner, Ranking Member Scott, Mr. Gowdy, and other Members of this great Committee, thank you for granting me a few minutes to speak on an epidemic that quietly began in rural parts of Kentucky, West Virginia, and Virginia, one doctor at a time, and now grips every corner of our great Nation in prolific fashion. As you will no doubt hear from the panelists and fellow Members of the Congressional Caucus on Prescription Drug Abuse, the statistics about this problem speak volumes.

In 2010, Mr. Chairman, 254 million prescriptions for opioids were filled in the U.S. That is enough painkillers to medicate every single American adult around the clock for a month. ONDCP has identified prescription drugs as the fastest growing drug problem, easily eclipsing cocaine and heroin abuse.

Our military soldiers are coming back from war hooked on these pain pills. In the last 2 years, over 150 soldiers have died from overdoses. In my home state, we are losing about 82 people a month to prescription drug abuse. More than car crashes. Our medicine cabinets are more dangerous than our cars.

But statistics are just numbers. The four of us on this panel each have been touched in a personal way by this tragedy. In some counties in my district, Mr. Chairman, 50 percent of all children are living in a home without their parents, over half, in large part, because of prescription drug abuse.

I have met with single moms struggling to get through drug court, kids living with foster parents, unsure of where their real

parents are. We have lost mothers, grandfathers, police officers to this scourge. My home county sheriff, Sam Catron, community leader, personal friend, dedicated public servant, was assassinated, because of his pursuit of prescription drug traffickers. A tragic loss. My field representative's nephew, a physician in my district, was shot down, senselessly, by a disgruntled drug abuser unable to get his fix.

The most dangerous job in my district? The driver of a delivery truck, UPS, FedEx, carrying drugs by mail. I suspect my colleagues have similar stories that they would share. This epidemic touches big city movie stars and rugged mountain men, and it has to stop.

We all recognize that this problem will require a coordinated multi-pronged approach that incorporates law enforcement, treatment, education, and research. I have worked closely with Congressman Frank Wolf, to stand up a leading grant program in the Department of Justice, which supports State-run prescription drug monitoring programs. PDMPs monitor the sale and purchases of controlled substances, bridging the gap between legitimate medical need and potential misuse.

Since 2002, we have seen the number of States with authorized PDMPs triple from 15 to 48. That is a huge accomplishment, but our work is nowhere near done. The next challenge will be facilitating the secure interstate exchange of data among these PDMPs, so we can eliminate once and for all the doctor shopping which has fueled the pill pipeline around our country.

In the next few weeks, I plan to introduce legislation to support the DOJ in opening up lines of communications between States. At the appropriate time, I would request that you give this bill, Mr. Chairman, your immediate consideration.

I also helped to establish an organization in my congressional district called Operation UNITE, standing for Unlawful Narcotics, Investigations, Treatment, Education. It is a bright star in our charge to empower our youth and create an anti-drug culture, and knock out abuse for good. So far, on the law enforcement side of that organization, it covers some 42 counties. Those undercover agents, some 30 of them, have sent to the prison around 4,000 pushers, in just my district.

UNITE, with its focus on investigations, treatment, and education, is a fantastic model, ripe for replication around the country. Operation UNITE is the lead sponsor for the national RX drug summit later this spring in Florida.

Collectively, Ms. Bono Mack, Mr. Rahall, Mr. Lynch, and others have introduced a number of bills focused on law enforcement, prescriber education, and research that would help to curb the rising tide of abuse. Many of them have been referred to this Subcommittee.

While I appreciate the opportunity to elevate this issue, which continues to plague my people and communities around the country, I would much rather see your Subcommittee mark up these bills, move the ball forward, and take decisive action to end this debilitating drug problem. And I stand ready, Mr. Chairman, Members of the Committee, willing and able to assist you in any way that you might request.

[The prepared statement of Mr. Rogers follows:]

Congressman Hal Rogers
Statement for the Record

March 7, 2012

House Judiciary Committee
Subcommittee on Crime, Terrorism and Homeland Security

"The Prescription Drug Epidemic in America"

Introduction

Chairman Sensenbrenner, Ranking Member Scott and other distinguished Members of the subcommittee, as Co-Chairman of the Congressional Caucus on Prescription Drug Abuse, I would like to thank you for affording me the opportunity to share some insights about an epidemic that has touched every corner of our great nation and which threatens the very fiber of our American culture.

Over a decade ago, prescription drug diversion began to wreak havoc on communities in my region of Appalachian Kentucky. Local hospitals were experiencing more than an overdose per week, families had been overrun by pain pills, and a feeling of hopelessness had begun to pervade the entire region. These powerful drugs intended to *manage* pain were suddenly *creating* pain in the form of overdoses, crime and uncontrollable addiction. While the first wave hit Appalachia, this second wave is hitting America.

Now the diversion of prescription pills is the fastest growing drug problem nationwide with abuse transcending state lines and socio-economic groups. According to the most recent Centers for Disease Control (CDC) data, more people are losing their lives to prescription painkiller overdoses each year than to heroin and cocaine combined. In my state of Kentucky, the picture is even more dire. We are losing 82 people a month to this epidemic, which is a higher rate than car accidents; tragically, our medicine cabinets are more deadly than our cars. The human element aside, the non-medical use of prescription drugs costs health insurers up to $72.5 billion annually in direct health care costs.

We in Congress have a special responsibility to approach this problem thoughtfully and proactively, with an eye to solutions that can curb the rising tide of prescription drug abuse to save our people's lives. For that reason, I joined with my esteemed colleague Mary Bono Mack in establishing the Congressional Caucus on Prescription Drug Abuse. Those of us on the caucus recognize that combating this problem will require a multi-disciplinary approach, incorporating law enforcement, education, treatment and research, and collaboration at all levels of government.

Importance of State-Run Prescription Drug Monitoring Programs

For over a decade, state-run Prescription Drug Monitoring Programs (PDMPs) have been among the most effective and accessible tools to combat prescription drug diversion and abuse, bridging the gap between legitimate medical need and potential misuse. PDMPs acknowledge that a

family doctor, a neighborhood pharmacist and a local law enforcement officer are all critical to keeping these drugs from diversion or abuse. Monitoring programs track vital prescription data so that doctors and pharmacists know when a prescription is being abused and investigators can root out bad doctors who are aiding drug dealers and addicts.

In the Commonwealth, the Kentucky All Schedule Prescription Electronic Reporting System (KASPER) has had unprecedented success in bringing this problem under control. In 2008, KASPER processed nearly 418,000 requests for patient prescription information. Of the 94% which came from the medical community, including physicians, ER doctors and pharmacists, nearly three-quarters of them say KASPER is "important" in helping to ascertain patient intentions and patterns, and to feel comfortable writing prescriptions for patients truly in need of medical attention. In the same year, just over 11,000 KASPER requests came from the law enforcement community, and 96% of these KASPER users agree that the PDMP is an excellent tool for obtaining evidence in criminal investigations.

These reports create informed decision-making for good medicine and good law enforcement. I have heard anecdotally of countless occasions where KASPER has helped a doctor provide better patient care or a law enforcement official interrupt a crime. Since 2002, the U.S. Department of Justice Prescription Drug Monitoring Grant Program has awarded over $62 million to nearly every state to plan, implement and enhance similar state-run programs. Because of these efforts, thirty-five other states are catching on with operational PDMPs, perhaps most notably Florida, where just twelve short months ago almost 90% of the oxycodone was prescribed in the U.S. Only two states have yet to authorize a PDMP, and Missouri is blazing forward thanks to the tireless work of State Senator Kevin Engler. Nationwide, since 2003, there has been a 2,596% increase in the number of prescription reports produced by state-run PDMPs annually – but challenges still persist.

Through interstate doctor shopping, such as that which was occurring between South Florida and Appalachia, unscrupulous drug dealers have found a mechanism to circumvent these vital state-based tracking systems. Critical to shutting down this pipeline will be the next generation of PDMP. In recent years, DOJ has acknowledged the importance of facilitating secure interstate data sharing among PDMPs and has supported the development of national standards to enable such interoperability, as well as an interstate data sharing "hub." I am proud that the hub was successfully piloted between Kentucky and Ohio, two of the premiere PDMPs in the country. Further, DOJ is poised to support the engagement of additional states with this hub through the formalization of the Prescription Monitoring Information Exchange (PMIX) Architecture, a formal set of technical requirements with which existing and future interstate data sharing hubs must comply to enable state-to-state communication.

I am pleased that important steps have recently been undertaken to facilitate interstate data exchange, but more still needs to be done. Last year, I authored legislation included in our final FY12 Appropriations bill that will allow the Department of Veterans Affairs to interface with state-run PDMPs, which will be integral to supporting our brave military men and women

returning from theater. I am also pleased to announce that in the next few weeks, I'll be introducing another bill, alongside a Senate companion, to support states from a technical perspective as they move towards interoperability. This bill likely will be referred to your subcommittee, and given the urgency and precariousness of the situation, I would appreciate your hasty consideration of this important legislation.

Collaboration of Federal, State, Local and Regional Law Enforcement

While PDMPs are perhaps the most accessible tool at the disposal of medical community, we must not understate the importance of collaboration among our federal, state, local and regional law enforcement partners in shutting down the pill pipeline and putting bad actors behind bars.

This Administration, under the leadership of Office of National Drug Control Policy (ONDCP) Director Gil Kerlikowske, has rightfully made prescription drug abuse a top priority. While approaching the problem with a wide-angle lens, law enforcement has been a key cog in the wheel. For example, after I engaged Attorney General Holder about the dire situation in South Florida last year, the Drug Enforcement Agency (DEA) moved three tactical diversion squads to that region to crack down on the pill mills which were funneling drugs all across the eastern seaboard. Through Operation Pill Nation, over 100 individuals were arrested, over $19 million in cash and assets seized and a number of suspension orders issued to rogue doctors and pharmacies. In just a year, there has been a 97% decrease in oxycodone purchases by doctor in Florida, and the number of Florida doctors in the nationwide list of the top 100 purchasing physicians dropped from 90 to 13.

This is a prime example where collaboration among law enforcement officials can bring about dramatic and positive results. Agencies participating in Operation Pill Nation include: the Broward County Sheriff's Office, Palm Beach County Sherriff's Office, Miami-Dade County Police Department, Hollywood Police Department, Sunrise Police Department, Fort Lauderdale Police Department, the Florida Highway Patrol, the Florida Department of Health, and the Florida Department of Law Enforcement. In my region of Kentucky, I have seen DEA work hand-in-hand with state and local law enforcement, as well. This is a model we must continue to replicate across the country, particularly as federal, state and local budgets continue to be squeezed.

As we have successfully cracked down on the problem in South Florida, pill mills are popping up in other hot spots, notably Tennessee, Georgia and my region of Kentucky. For this reason, we must be ever vigilant and allocate our scarce law enforcement resources with precision. I am proud to support legislation sponsored by Congressman Vern Buchanan of Florida that would employ the full gamut of federal resources to crack down even more aggressively on these pill mills, and I am exploring the possibility of introducing legislation that would provide the DEA greater flexibility to track the prescription drug supply chain through the Automation of Reports and Consolidated Orders System (ARCOS).

Community Engagement, Education & Treatment

While monitoring programs and law enforcement have risen to meet the challenges of identifying abuse and diversion, buy-in from local communities might be the single most

important factor in developing an anti-drug culture in towns across the country. I was proud to welcome Director Kerlikowske to my congressional district last year. When I showed him the front page of our local paper, there were some notable omission – no stories about the town fair or the community pot lock. The front page was chalk full of articles about prescription drug abuse – arrests, thefts, the abandonment of children, and tragically, deaths. To spend a few days in my district, one would think that the situation is truly cyclical and hopeless. However, while I believe the Director has appreciation for the challenges we're facing with the abuse of these drugs in Kentucky, I don't think he left with that impression that we can't pull ourselves out of this mess.

In Southern and Eastern Kentucky, we've been employing a multi-pronged approach to combating this abuse for years through Operation UNITE. Since inception, more than 3,100 addicts and non-violent offenders who have fallen prey to this scourge have participated in a UNITE-funded drug court or treatment program, restoring hope and creating opportunity. In addition, 93 schools in 23 southern and eastern Kentucky counties have a UNITE club, encouraging our children to remain drug-free and offering counseling programs. There are countless UNITE Community Coalitions throughout my congressional district, which support educational and faith-based conferences, medical symposiums, technical trainings and health care workshops. Many of these coalitions have received federal support through the Office of National Drug Control Policy (ONDCP) Drug-Free Communities Grant program. Operation UNITE is a bright star in our charge to empower our youth, create an anti-drug culture and knock out abuse for good, and a clear indication that our fight against drug abuse is rooted in small communities across the country. I am pleased that Director Kerlikowske had a desire and an opportunity to witness first-hand the positive impact of this program in our region, and hope that it is a model that can be replicated in communities across the nation.

Research

Finally, we must continue to support research in the pharmaceutical industry and in academic settings which lead to innovation both in the treatment of pain and in the science of recovery. Tremendous strides have been made by researchers on the development of abuse-deterrent formulations of pain medication, which will be vital to ensuring that patients with legitimate needs continue to have access to these life-changing drugs, as well as alternatives to the traditional replacement therapy treatment paradigm. To that end, we must push for a regulatory environment which encourages such innovation and gets new, safe drugs to the marketplace while also ensuring that insurance companies have the adequate incentives to cover drugs and treatments aimed at curbing the abuse of these prescription medications.

Conclusion

This will take a collaborative, multi-pronged effort -- law enforcement, treatment, education and research are all a part of the puzzle – and I am grateful to have the opportunity to share my perspective with you in the course of this important hearing. I encourage you and all the members of this subcommittee to take to heart all that has been said about the need for legislative action. It is one thing to listen solemnly about the plight of families, soldiers and children around the country; it is quite another to take meaningful and decisive action. The Judiciary

Committee, and specifically this subcommittee, is in a position to take just the decisive action we so desperately need on the streets of Boston, in suburban parts of LA, and countless communities in the South. A number of bills under your purview, to include H.R. 1065, the Pill Mill Crackdown Act, H.R. 1925, the Prescription Drug Abuse Prevention and Treatment Act, and H.R. 2119, the Ryan Creedon Act, would do wonders for my people struggling with addiction and thousands of others around the country. I urge you to give these important pieces of legislation serious consideration. Thank you.

Mr. SENSENBRENNER. Thank you very much, Mr. Rogers. And I understand that you have an appropriations meeting to go to. So, I think it is best we excuse you. But don't forget the appropriation for our Subcommittee for our Subcommittee, please. [Laughter.]

Mr. ROGERS. Rest assured, Mr. Chairman.

TESTIMONY OF THE HONORABLE NICK J. RAHALL, II, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. RAHALL. Thank you, Mr. Chairman. I appreciate the opportunity to be before your distinguished Committee today. And while I do outrank Mr. Rogers in seniority, I certainly agree with you yielding to him first, as the Chairman of the Appropriations Committee, and my dear friend and neighbor from across the river, in my district.

Mr. SENSENBRENNER. Praise will get you a long way, my friend.

Mr. RAHALL. I appreciate that, Mr. Chairman. And I certainly associate myself with his testimony, and commend him for his efforts in organizing UNITE, to which he referred in his testimony. I appreciate the efforts of my colleague from California, Ms. Bono Mack, and from Massachusetts, Mr. Lynch.

This is an issue that crosses all partisan lines, philosophical lines, class lines, every line in our society. This issue crosses and affects all of us.

I will be presenting testimony to the Subcommittee on behalf of law enforcement officials from my district, healthcare professionals, and community leaders. And I am sure this Subcommittee will make this testimony public in our continued efforts to educate the public and the American people as to this tremendous epidemic that faces all of us.

It was once described as America's silent epidemic, but it can now be openly witnessed any hour, any day, or any night on countless street corners across the country. It is the crippling epidemic of prescription drug abuse that we are facing. And every day we face new stories and reports of overdoses, deaths, accidents, families torn apart by the vicious cycle of prescription drug abuse.

Headlines such as this, dealing with addiction in McDonough County, in my district. These appear every day in every newspaper. And believe you, me, they are touching stories about how these communities are trying to deal with this vicious cycle.

Unlike cocaine or heroin, as Mr. Rogers has said, prescription drugs are legal, frequently prescribed by caring physicians, lead by the principle oath of "First, do no harm." Yet, alarming statistics show that children and adults are blind to the harmful consequences of these drugs. Even as they become addicted, paying upwards of $150 per pill to buy them on the black market.

Distressingly, my home State of West Virginia has our Nation's highest rate of drug-related deaths. In fact, between 2001 and 2008, more than 9 out of 10 of those deaths involved prescription drugs. And incredibly, as Mr. Rogers has, again, pointed out, drug overdoses now kill more West Virginians than car accidents.

But the alarming use and deaths by prescription drugs is not just in West Virginia. As our other distinguished Members will testify, it is across this country. And I could go into the figures, Mr. Chairman, but you have those figures as well, about what drug overdose death rates are in this great country, how they have tripled since 1990, and have never been higher in our Nation's history.

I have met numerous times with law enforcement, community organizations, educators, physicians, and many more of my constitu-

ents. We have had drug summits, and we will continue to have networking processes in which we try to involve all aspects of our community, and to involve those that are personally affected, to get them to get to communicate. If they don't want to openly, at least at these networking seminars, with those law enforcement officials with whom, perhaps, they have been afraid to have contact in the past, but now find a forum, and find other people in like circumstances as them, and which their fear is no longer preventing them from coming forward and telling what is happening on the streets, and how they feel the problem can be addressed.

So, these networks are important. This hearing is vitally important. We must strengthen drug diversion, educate our children and adults on prevention, work with the medical community on addiction and pain treatment, and treat and rehabilitate those that are affected by this vicious addiction before they succumb to the death spiral.

There are a number of pieces of legislation I and my colleagues have joined in cosponsoring. This Subcommittee is certainly aware of those. And I leave it in your wisdom to join these bills, perhaps, or to pick, as you see as most appropriate, which bills should make it to the floor of the House of Representatives. But many bills will establish mandatory physician and consumer education, as well as authorizing Federal funding to help States create and maintain prescription drug monitoring programs that all States can access.

This is one of the bills that I have introduced. It would set up a uniform system for tracking painkiller-related deaths, helping States and law enforcement personnel to be able to manage and report data. The West Virginia State Police, our attorneys general, and even physicians all consistently stress the need to access a prescription drug monitoring system that is shared between State lines and updated in real time.

So, Mr. Chairman, I urge you and this Subcommittee to consider and move forward on legislation that encompasses the provisions I have mentioned, and many others. Let us act with dispatch and compassion, with an acute understanding of the enormity of the challenge before us.

I conclude by thanking you once again for conducting this hearing, and allowing me and my colleagues to be with you.

[The prepared statement of Mr. Rahall follows:]

Testimony of U.S. Rep. Nick J. Rahall (WV03)
"The Prescription Drug Epidemic in America"
Committee on the Judiciary, Subcommittee on Crime, Terrorism and Homeland Security
Wednesday, March 7, 2012
10am
2141 Rayburn House Office Building

Thank you Chairman Sensenbrenner and Members of the Subcommittee for this hearing. Thank you to my colleagues – my good neighbor and Chairman of the Appropriations Committee, Hal Rogers, and Congresswomen Mary Bono Mack and Congressman Stephen Lynch – all tremendous leaders on our fight to stop this epidemic.

I appreciate the opportunity to appear before the Subcommittee and to submit statements on behalf of the law enforcement officials, health care professionals, and community leaders I represent. I encourage the Subcommittee make available the full record of this hearing to facilitate a deeper understanding of the drug challenge before us and the need for legislative action by the Congress.

What was once described as America's "Silent Epidemic," can now be openly witnessed any hour, day or night, on countless street corners across the country. It is the crippling epidemic of prescription drug abuse that we are facing. Every day, news stories report overdoses, deaths, accidents and families torn apart by the vicious cycle of prescription drug abuse.

And, the cycle is certainly vicious.

Unlike cocaine or heroin, prescription drugs are legal; frequently prescribed by caring physicians, led by the principle oath of "first, do no harm." Yet, alarming statistics show that children and adults are blind to the harmful consequences of these drugs – even as they become addicted – paying upwards of $150 per pill to buy them on the black market.

Distressingly, West Virginia has our nation's highest rate of drug-related deaths. In fact, between 2001 and 2008, more than nine out of ten of those deaths involved prescription drugs. Incredibly, drug overdoses now kill more West Virginians each year than car accidents.

But the alarming use and deaths by prescription drugs is not just in West Virginia. As the other distinguished Members of this panel can tell you, they are seeing and hearing of this epidemic from their communities, as well.

Drug overdose death rates in the United States have more than tripled since 1990 and have never been higher. In 2008, more than 36,000 people died from drug overdoses, and most of these deaths were caused by prescription drugs. From newborn babies addicted to opiates to seniors overdosing, this nationwide problem knows no boundaries and it needs national attention.

I have met numerous times with law enforcement, community organizations, educators, physicians, and many more of my constituents. Clearly, fighting back against prescription drug

abuse will take the efforts of an entire village with determination and persistence and the coordination of federal, state, and local resources and networks.

We must strengthen drug diversion, educate children and adults on prevention, work with the medical community on addiction and pain treatment, and treat and rehabilitate those affected by vicious addiction before they succumb to the death spiral.

I, and my distinguished colleagues, have put forth and supported legislation that aims to combat prescription drug abuse. We know that something more needs to be done from a federal level, and that's why I introduced H.R. 1925, the Prescription Drug Abuse Prevention and Treatment Act. This bill would implement multiple measures essential to combating prescription drug abuse – education and training, monitoring, evaluation and enforcement – and it provides a good guideline to coordinate federal, state, and local efforts to fight this epidemic.

The bill establishes mandatory physician and consumer education, as well as authorizes federal funding to help states create and maintain prescription drug monitoring programs that all states can access. The bill would also set up a uniform system for tracking pain killer-related deaths, helping states and law enforcement manage and report data. The West Virginia State Police, our state's Attorney General, and even physicians all consistently stress the need for access to a prescription drug monitoring system that shared between state lines and updated in real time.

I know my colleagues have authored and support similar bills, like H.R. 2119, the Ryan Creedon Act, which also seeks to implement targeted physician education on prescription drug abuse and addiction.

These bills address the critical issues that ought to be part of this Subcommittee's efforts to craft legislation to assist our states and communities in combating prescription drug abuse.

From the evidence submitted to this Subcommittee, one unmistakable conclusion emerges. The toll of destruction and devastation heaped upon America's families and our economy by this epidemic demands the United States Congress must act, and act swiftly.

I urge you, Mr. Chairman, to strongly consider and move forward on legislation that encompasses the provisions I've mentioned. Let us act with dispatch and compassion and with an acute understanding of the enormity of the challenge before us.

I thank you for your time today, and with the aid of legions of willing and able community professionals and leaders throughout the country, I look forward to working with you and my colleagues in the coming weeks and months to fashion a national response.

Mr. SENSENBRENNER. Thank you very much, Mr. Rahall.
Ms. Bono Mack.

TESTIMONY OF THE HONORABLE MARY BONO MACK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. BONO MACK. Thank you, Mr. Chairman. I am honored to be here with my colleagues, as you hold this critically important hearing on the growing and deadly dangers prescription drug abuse poses to our Nation.

One incident last year, in particular, graphically captures the seriousness of this issue. On June 19th, in Medford, New York, a man walked into a pharmacy and murdered four people for 11,000 tablets of Hydrocodone. One of those gunned down was a 33-year-old customer, who was just engaged to be married. Instead, she was buried in her wedding dress. A 17-year-old pharmacy employee was also killed, and later buried in her prom dress, along with her high school diploma.

This senseless tragedy is just one example of a growing wave of drugstore robberies by prescription drug addicts. But it is also part of a larger rapidly escalating struggle nationwide against prescription drug abuse and addiction, which is expected to claim the lives of nearly 30,000 Americans this year. Just last weekend, I met in California with dozens of parents who have lost children to this horrible epidemic.

Two classes of medicines, painkillers, and insomnia and anxiety drugs, are responsible for about 70 deaths and nearly 3,000 emergency room visits every day. That is right, a day. And these are truly stunning numbers.

But what is very insidious is the way these powerfully addictive narcotic prescription drugs quickly turn people, without any real emotional or physical problems into desperate people suddenly facing life-or-death struggles. Few things are more destructive.

According to the CDC, drug overdose is now the leading cause of injury death in the United States, not just in West Virginia, but in the United States, in large part due to prescription drug abuse. It is not hard to understand why. Today, some 12.5 million Americans regularly abuse prescription drugs, and the problem, as I have said, is growing rapidly. There are approximately 7,000 new abusers every day, many of them teenagers and young adults.

This alarming trend, now a health epidemic, according to CDC, is taking a huge toll on society. Today, the abuse of prescription drugs, especially painkillers, stimulants, and depressants, is the fastest growing drug problem in America.

As Chairman of the House Subcommittee on Commerce, Manufacturing, and Trade, which has jurisdiction over consumer protection, I have made combating prescription drug abuse a top priority. I believe there needs to be a national awakening about the threat this alarming epidemic poses to our families and to our communities. Simply put, we are in the midst of an American tragedy.

What can we do? For starters, we must do a better job of monitoring and limiting access to prescription drugs containing controlled-release oxycodone hydrochloride, including the popular painkiller and killer, OxyContin.

Originally, OxyContin was intended to be prescribed only for severe pain, as a way to help patients dealing with last-stage cancer and other severe illnesses. Today, however, more and more people

across America are prescribed OxyContin, as well as other generic oxycodone drugs for less severe reasons, clinically known as moderate pain, greatly expanding the availability and potential for abuse of these powerful addictive narcotics. Someone with a toothache or a sore knee should not be prescribed a potentially addictive painkiller.

Clearly, expanded public education plays a role in addressing the problem, but we are not going to make any real progress until we limit access to these powerful narcotic drugs, and ensure that only patients in severe pain can obtain them.

We must also improve prescriber education by getting doctors, dentists, nurse practitioners, and other prescribers up to speed on the dangers of addiction. Today, I have legislation pending in Congress, the Ryan Creedon Act, H.R. 2119, to accomplish this goal.

The pervasiveness of prescription drug abuse made national headlines when Federal, State, and local law enforcement agencies, led by the DEA, cracked down on so-called pill mills in Florida, where painkillers were routinely dispensed just like M&Ms from a gumball machine.

Congress needs to make it much more difficult for these rogue pain clinics to operate, and we should treat offenders like any other street drug dealer. By better coordinating the efforts of local, State, and national agencies, and by reducing the supply of highly addictive opioid painkillers, I am convinced that we can eventually save thousands of lives, and spare millions of American families from the heartache of addiction. Mr. Chairman, no child should ever be buried in a prom dress again, because we ignored this problem.

And I just want to say, in closing, that this past weekend, when I met with these parents, a number of them spoke about a Dr. Lisa Tseng, in Rowland Heights, California, who is being charged for three counts of murder for supplying prescription drugs to young men, who all overdosed. These parents went and confronted the doctor, and she showed absolutely no remorse, whatsoever. And I think we should do all we can to ensure she is put away for a very, very long time, if she is found guilty.

So, thank you very much for allowing me to testify today.

[The prepared statement of Ms. Bono Mack follows:]

COMMITTEE:
ENERGY AND COMMERCE

SUBCOMMITTEES:
CHAIRMAN, COMMERCE, MANUFACTURING AND TRADE
COMMUNICATIONS AND TECHNOLOGY
ENVIRONMENT AND ECONOMY

Mary Bono Mack
Congress of the United States
45th District, California

WASHINGTON OFFICE:
104 Cannon House Office Building
Washington, DC 20515
(202) 225-5330
Fax: (202) 225-2961

DISTRICT OFFICES:
38-050 Cook Street
Suite 104
Palm Desert, CA 92211
(760) 323-1076
Fax: (760) 340-0358

1600 East Florida Avenue
Suite 301
Hemet, CA 92544
(951) 658-2312
Fax: (951) 652-2502

The Prescription Drug Epidemic in America
House Judiciary Committee
Subcommittee on Crime, Terrorism, and Homeland Security

Wednesday, March 7, 2012
10:00 AM
2141 Rayburn House Office Building

Written Statement of
U.S. Representative Mary Bono Mack

Statement of U.S. Representative Mary Bono Mack

before the

Subcommittee on Crime, Terrorism, and Homeland Security
Judiciary Committee
U.S. House of Representatives

March 7, 2012

Thank you, Mr. Chairman, for holding this critically important hearing on the growing and deadly dangers prescription drug abuse poses to our nation. One incident last year, in particular, graphically captures the seriousness of this issue.

On June 19th in Medford, New York, a man walked into a pharmacy and murdered four people for 11,000 tablets of hydrocodone – an opioid used to manufacture a long list of narcotic pain killers, including Vicodon. One of those gunned down was a 33-year-old customer engaged to be married. Instead, she was buried in her wedding dress. A 17-year-old pharmacy employee was also killed and later buried in her prom dress along with her high school diploma.

This senseless tragedy is just one example of a growing wave of drug store robberies by prescription drug addicts. But it's also part of a larger, rapidly escalating struggle nationwide against prescription drug abuse and addiction, which is expected to claim the lives of nearly 30,000 Americans this year.

Just last weekend, I met in California with dozens of parents who have lost children to this horrible epidemic.

Two classes of medicines – painkillers, and insomnia and anxiety drugs – are responsible for about 70 deaths and nearly 3,000 emergency room visits a day. That's right – a day. These are truly stunning numbers.

Why is it happening? Scientists tell us that childhood trauma, genetics, mental disorders, depression, stress, anxiety, thrill seeking, peer pressure, severe pain from injuries and illnesses and even the horrors of combat all contribute to prescription drug addictions, which often lead to tragic and avoidable deaths.

But what's even more insidious is the way these powerfully addictive narcotic prescription drugs quickly turn people without any real emotional or physical problems into desperate people suddenly facing life-or-death struggles. Few things are more destructive.

According to the Centers for Disease Control and Prevention, drug overdose is the now leading cause of injury death in the United States – in large part due to prescription drug abuse.

It's not hard to understand why. Today, some 12 and a half million Americans regularly abuse prescription drugs, and the problem is growing rapidly. There are approximately 7,000 new abusers every day -- many of them teenagers and young adults. This alarming trend – now a health epidemic, according to CDC -- is taking a huge toll on society.

Today, the abuse of prescription drugs – especially painkillers, stimulants and depressants -- is the fastest-growing drug problem in America. As Chairman of the House Subcommittee on Commerce, Manufacturing and Trade – with jurisdiction over consumer protection – I have made combating prescription drug abuse a top priority. I believe there needs to be a national awakening about the threat this alarming epidemic poses to our families and our communities. Simply put, we are in the midst of an American tragedy.

What can we do? For starters, we must do a better job of monitoring and limiting access to prescription drugs containing controlled-release oxycodone hydrochloride, including the popular pain killer OxyContin.

Originally, OxyContin was intended to be prescribed only for severe pain as a way to help patients dealing with late-stage cancer and other severe illnesses.

Today, however, more and more people across America are being prescribed OxyContin, as well as other generic oxycodone drugs, for less severe reasons – clinically known as moderate pain – greatly expanding the availability and potential for abuse of these powerfully-addictive narcotics. Someone with a toothache or a sore knee should not be prescribed a potentially addictive painkiller.

Clearly, expanded public education plays a role in addressing this problem, but we're not going to make any real progress until we limit access to these powerful narcotic drugs and ensure that only patients in severe pain can obtain them.

We must also improve prescriber education by getting doctors, dentists, nurse practitioners and other prescribers up to speed on the dangers of addiction. Today, I have legislation pending in Congress, the Ryan Creedon Act, HR 2119, to accomplish this goal.

The pervasiveness of prescription drug abuse made national headlines when federal, state and local law enforcement agencies, led by the Drug Enforcement Administration, cracked down on so-called "pill mills" in Florida, where painkillers were routinely dispensed like M&Ms from a gumball machine.

Congress needs to make it much more difficult for these rogue pain clinics to operate, and we should treat offenders like any other street drug dealer. By better coordinating the efforts of local, state and national agencies – and by reducing the supply of highly addictive opioid

painkillers – I am convinced that we can eventually save thousands of lives and spare millions of American families from the heartache of addiction.

Mr. Chairman, no child should ever be buried in a prom dress again because we ignored this problem.

4

Mr. SENSENBRENNER. Thank you very much.
Mr. Lynch.

TESTIMONY OF THE HONORABLE STEPHEN F. LYNCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. LYNCH. Thank you, Mr. Chairman, and Ranking Member Scott, for your kindness in allowing us to testify on this important issue.

My colleagues have told the story of drug abuse in America today, but I do want to amplify the issue that Ms. Bono was speak-

ing about, and that is OxyContin. I will associate myself with the remarks of the 3 previous speakers, and rather than take my whole 5 minutes, I just want to offer a couple thoughts.

Number one, this OxyContin is so powerful, it is so powerful that in a very limited period of time a person who is prescribed this becomes addicted. And we have seen stats now that 99 percent of addicts who are involved with heroin, that are in facilities today in the United States, started on OxyContin. And the pattern is that they stay on OxyContin until they are financially unable to do so, and then they switch over to heroin, which is much, much cheaper.

But when you allow a company to create a product that is so powerfully addictive that in a very short time they create customers for life, that is a very troubling situation. It got so bad in my district that I had to create, well, a residential rehab facility, first, for boys, and then later for girls, because these kids are getting addicted so young, there is nowhere else to send them. We didn't have any adolescent rehab facilities in my State. So, we had to create two.

We have a situation now where Perdue Pharma lost their exclusivity, and now OxyContin is going to go generic. This is tremendously powerful. And think about this, the profits here are enormous. We are creating a national healthcare system that will allow all of these people to continue to financially get the support from these pill mills, the drug from these pill mills, having the American taxpayer contribute to that. So, this is a very, very dangerous situation.

And I noticed that on March 1, OxyContin was actually pulled from the shelves in Canada. That is according to the Toronto Star and the CBC news. I sponsored legislation here in Congress several years ago to remove OxyContin from the market. But, let's face it, there are so many drug company lobbyists up here that that bill didn't have a prayer, because the pharmaceutical company lobbyists outnumber Members of Congress probably 7 to 1.

We have a serious problem here. And I commend you for giving us the time here to try to address it. And I commend my colleagues for the fights that they are making in their own districts, and now, hopefully, we will be able to collectively use our experience to push this issue nationally.

So, I thank you for your time. I appreciate it. And I yield back the balance of my time.

[The prepared statement of Mr. Lynch follows:]

STEPHEN F. LYNCH
9TH DISTRICT, MASSACHUSETTS

COMMITTEE ON FINANCIAL SERVICES
SUBCOMMITTEE ON CAPITAL MARKETS AND GOVERNMENT-SPONSORED ENTERPRISES
SUBCOMMITTEE ON FINANCIAL INSTITUTIONS AND CONSUMER CREDIT
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
RANKING MEMBER, SUBCOMMITTEE ON FEDERAL WORKFORCE, U.S. POSTAL SERVICE, AND LABOR POLICY
SUBCOMMITTEE ON NATIONAL SECURITY, HOMELAND DEFENSE AND FOREIGN OPERATIONS
SUBCOMMITTEE ON TECHNOLOGY, INFORMATION POLICY, INTERGOVERNMENTAL RELATIONS AND PROCUREMENT REFORM

ASSISTANT DEMOCRATIC WHIP

Congress of the United States
House of Representatives
Washington, DC 20515-2109

2349 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-8273
(202) 225-3984 FAX

88 BLACK FALCON AVENUE
SUITE 340
BOSTON, MA 02210
617-428-2000
617-428-2011 FAX

PLYMOUTH COUNTY REGISTRY BUILDING
155 WEST ELM STREET
SUITE 200
BROCKTON, MA 02301
508-586-5555
508-580-4692 FAX

WWW.HOUSE.GOV/LYNCH

TESTIMONY BEFORE THE
HOUSE COMMITTEE ON THE JUDICIARY SUBCOMITTEE ON CRIME,
TERRORISM AND HOMELAND SECURITY
THE PRESCRIPTION DRUG EPIDEMIC IN AMERICA
WEDNESDAY, MARCH 7, 2012, 10:00 A.M.

REPRESENTATIVE STEPHEN F. LYNCH

Good morning, Mr. Chairman, ranking member Scott and Members of the Committee. First let me thank you for providing my colleagues and me with the opportunity to testify on the very important issue of prescription drug abuse.

I appreciate that this is a broad hearing on the issue, which is appropriate, because it is multi-layered and has wide-ranging impact.

Prescription drug abuse in the United States is an epidemic, plain and simple.

In fact, according to the centers for disease control (CDC), prescription drugs cause most of the more than 26,000 fatal overdoses each year.

If that many people died from avian flu or some other virus it would make headlines around the world. And that is part of the problem we face. There is a misperception about substance abuse that prevents many people from identifying it as the problem it is. That in turn makes it more difficult to find a real solution.

My colleagues and I are here today to refute that misperception, to testify that this is not an inner city problem or a problem that affects only those who have made the wrong choices in life.

The four of us, Mr. Rogers, Mr. Rahall, Ms. Bono Mack, and myself, represent districts that individually and together reflect the diversity of America.

Many of our constituents struggle with prescription drug addiction and its consequences.

Abuse of prescription medicine, especially pain relievers, is a major problem nationally, and particularly in Massachusetts, where deaths, emergency room episodes and admissions for treatment related to non-heroin opioids has skyrocketed in recent years. Of the five thousand adults admitted to recovery home in Massachusetts in 2011, nearly 30% listed "other opiate".

I have been exposed to this problem since before I entered elective office and continue to be frustrated by its proliferation.

The Boston Public Health Commission reports in its "Health of Boston 2010", that the substance abuse treatment rate for my neighborhood of South Boston is 48 admissions per 1000 residents. That's nearly 5 % of the population. And those are only the people who are getting help. Sadly, the report also revealed that South Boston had the highest average annual opioid mortality rate in the City of Boston.

A regional, newspaper, *The Quincy Patriot Ledger*, reported recently that an overdose claims 1 life every 8 days in Massachusetts South Shore communities. And there is no distinct pattern to the victims. With a median age of 41 years, they are homemakers, professionals, students, and laborers. Addiction does not discriminate.

We spend precious public and private dollars on substance abuse programs to help individuals and families who have chosen to face the problem and get help. There are many dedicated people in the treatment community who are doing wonderful work. But they are treating increasing numbers of new and relapsed admitants, very often with shrinking budgets.

About five years ago, the Massachusetts bureau of substance abuse services launched a pilot program of providing naloxone (nal-ox-one) – a medicine that blocks opioids and reverses opioid overdose – to people considered high risk. The program met with such success that the state of Massachusetts expanded it. While this is positive news, there needs to be a better way to prevent an overdose. We need to prevent it from getting to that point.

Prescription pain medication helps many people suffering from a range of chronic and temporary conditions. But for some, exposure to pain medication, whether prescribed or obtained through other non-nefarious means, can be the beginning of a long, tragic battle. We are all aware of the slippery slope associated with addiction to prescription drugs. 99% of individuals entering treatment facilities who report heroin use started with prescription medication like oxycontin.

We, more than most, are in a position to do something about it.

In addressing the problem we need to consider the myriad contributing factors. We need to look at composition and marketing of these addictive drugs, the regulatory approval process and labeling requirements. We need to improve training and education for all parties – medical professionals, law enforcement, government and individuals and families. And we need to deal with access to and disposal of these drugs. This is a complex problem that will require a coordinated effort to solve.

I commend my colleagues on the congressional prescription drug abuse caucus for their legislative efforts and look forward to continuing to work with them on this very important issue.

Thank you again, Mr. Chairman, for recognizing the importance of this topic.

Mr. SENSENBRENNER. Thank you, Mr. Lynch.

I would like to thank all of the Members of Congress who took time out of their schedules to come and testify here, as well as the Members on the Subcommittee who have come and listened to all of these graphic stories. And I am sure that this is just the tip of the iceberg. This is a very serious issue. It is one that needs to be addressed, and it needs to be addressed in the proper manner.

Does the gentleman from Virginia have anything else he wants to say or to insert into the record?

Mr. SCOTT. Yes, Mr. Chairman. Another Rand study showing that demand investments work better than supply control.

Mr. SENSENBRENNER. Without objection, the material is inserted.

[The information referred to follows:]

RAND

Controlling Cocaine

Supply Versus Demand Programs

C. Peter Rydell
Susan S. Everingham

Prepared for the Office of
National Drug Control Policy
United States Army

DRUG POLICY RESEARCH CENTER

Approved for public release; distribution unlimited

The research described in this report was sponsored by the Office of National Drug Control Policy, by the United States Army, and by RAND's Drug Policy Research Center with funding from The Ford Foundation.

ISBN: 0-8330-1552-4

RAND is a nonprofit institution that seeks to improve public policy through research and analysis. RAND's publications do not necessarily reflect the opinions or policies of its research sponsors.

Published 1994 by RAND
1700 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138
To order RAND documents or to obtain additional information, contact Distribution Services: Telephone: (310) 451-7002; Fax: (310) 451-6915; Internet: order@rand.org.

The current cocaine epidemic in the United States started in the late 1960s, picked up momentum during the 1970s, and is still going strong in the 1990s. The number of cocaine users peaked in the early 1980s at about 9 million, and has gradually decreased to a little more than 7 million today. However, that downward trend in the total number of users is misleading, because a decline in the number of light users has masked an increase in the number of heavy users.[1]

Heavy users consume cocaine at a rate approximately eight times that of light users, so the upward trend in consumption by heavy users roughly cancels the downward trend in consumption by light users. The result is that total consumption of cocaine in the United States has remained at its mid-1980s peak for almost a decade (see Figure S.1).

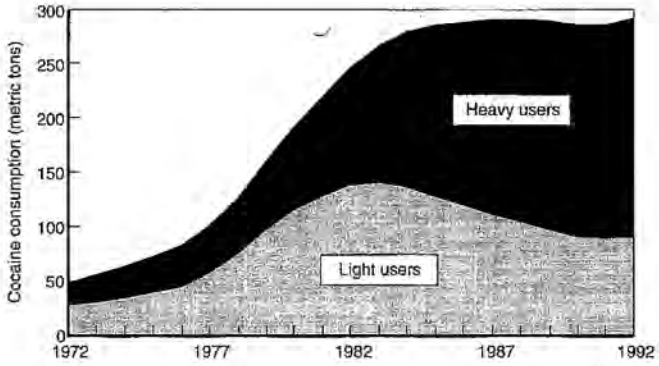


Figure S.1—Cocaine Consumption, by Type of User: 1972–1992

[1]This analysis defines "heavy use" as once a week or more and "light use" as at least once a year, but less than weekly. At the end of 1992, there were an estimated 5.6 million light users and 1.7 million heavy users, by these definitions.

The persistence of high levels of cocaine consumption indicates the magnitude of the cocaine problem and the need for government to think carefully about its response. Part of thinking carefully includes estimating the relative cost-effectiveness of various available interventions. Four such interventions analyzed in this report are:

- **Source-country control**: coca leaf eradication; seizures of coca base, cocaine paste, and the final cocaine product in the source countries (primarily Peru, Bolivia, and Colombia).
- **Interdiction**: cocaine seizures and asset seizures by the U.S Customs Service, the U.S. Coast Guard, the U.S. Army, and the Immigration and Naturalization Service (INS).
- **Domestic enforcement**: cocaine seizures, asset seizures, and arrests of drug dealers and their agents by federal, state, and local law enforcement agencies; imprisonment of convicted drug dealers and their agents.
- **Treatment of heavy users**: outpatient and residential treatment programs.

This study analyzes the relative and, to a lesser extent, absolute cost-effectiveness of these programs. The first three programs focus on "supply-control." They raise the cost to dealers of supplying cocaine by seizing drugs and assets, and by arresting and incarcerating dealers and their agents. The increased production costs raise retail cocaine prices and thus reduce consumption, partly by discouraging current consumption and partly by modifying the flows of people into and out of cocaine use, so that the number of cocaine users gradually declines.

The fourth program is a "demand-control" program: It reduces consumption directly, without going through the price mechanism. Treatment reduces consumption in the short term, because most clients stop their cocaine use while in the program, and in the longer term, because some clients stay off heavy drug use even after treatment ends.

User sanctions (arresting and incarcerating people for using drugs) and drug-abuse prevention programs (both school-based and community-based) are also viable interventions, but analyzing them is beyond the scope of the present study.

To assess the cost-effectiveness of these programs, one needs to know (1) how much is being spent on them and (2) what benefits accrue from that spending. Determining current spending levels, although time-consuming in practice, is conceptually straightforward.

Currently, an estimated $13 billion is being spent in the United States each year on the four cocaine-control programs listed above. The bulk of these resources goes to domestic enforcement—drug busts, jails, and prisons are expensive. Treatment accounts for only a 7 percent share of this expenditure, even when privately funded treatment is included (see Figure S.2).

Measuring the benefits of the four programs is more difficult, in part because they produce disparate effects. Supply-control programs generate cocaine seizures, asset seizures, and arrest and imprisonment of drug dealers. Treatment programs induce

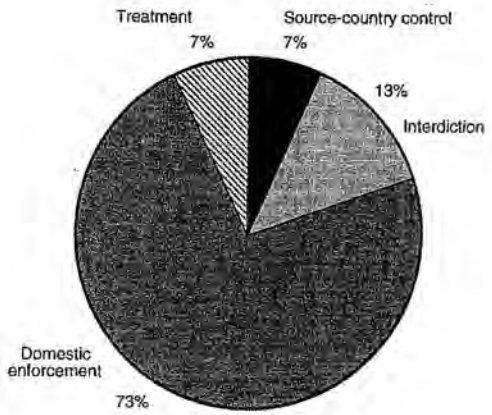


Figure S.2—Distribution of Annual Expenditure on Cocaine Control: 1992

people to stop using cocaine. These outcome measures cannot be directly compared; they must first be translated into a common measure of effectiveness. For much of this analysis, the common measure used is the cost of a given reduction in U.S. consumption of cocaine.

The analytical goal is to make the discounted sum of cocaine reductions over 15 years equal to 1 percent of current annual consumption. The most cost-effective program is the one that achieves this goal for the least additional control-program expenditure in the first projection year. The additional spending required to achieve the specified consumption reduction is $783 million for source-country control, $366 million for interdiction, $246 million for domestic enforcement, or $34 million for treatment (see Figure S.3). The least costly supply-control program (domestic enforcement) costs 7.3 times as much as treatment to achieve the same consumption reduction.

The short story behind the supply-control cost estimates is that money spent on supply-control programs increases the cost to producers of supplying the cocaine. Supply costs increase as producers replace seized product and assets, compensate drug traffickers for the risk of arrest and imprisonment, and devote resources to avoiding the seizures and arrests. These added costs get passed along to the consumer as price increases, which in turn decreases consumption.

For example, a $246 million additional annual expenditure on domestic enforcement causes annual cocaine supply costs to increase by an estimated $750 million, or 2 percent of the estimated $37.6 billion spent annually by consumers on cocaine. As-

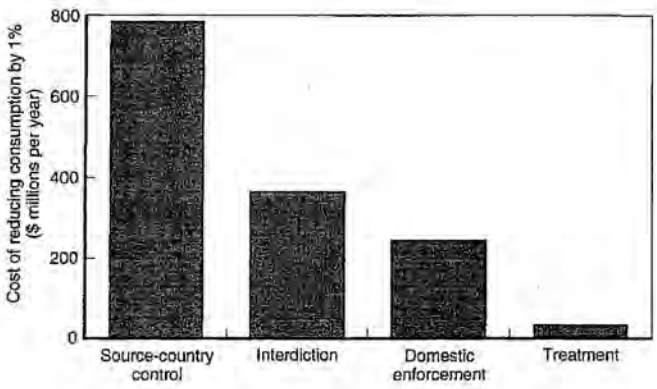


Figure S.3—Cost of Decreasing Cocaine Consumption by 1 Percent with Alternative Cocaine-Control Programs

suming that the percentage decrease in consumption caused by a price increase is half the percentage price increase, the additional control expenditure achieves the goal of reducing consumption by 1 percent.

The specific cost estimates for the supply-control programs are, of course, driven by the assumption that a 1 percent increase in price causes a 0.5 percent decrease in cocaine consumption. (Some of this consumption decrease occurs immediately as this year's price increase reduces current consumption; the rest occurs gradually over time as the price increase alters flows of people into and out of cocaine use.) If the consumption decrease caused by a price increase is large, the costs of achieving the specified consumption reduction with supply-control programs will be proportionately small. However, the finding that treatment programs are more cost-effective than enforcement programs is not in question, because the effect of price on consumption would have to be 7 times the assumed level to alter that conclusion.

The estimate that an additional $34 million dollars spent on cocaine treatment would reduce cocaine consumption by 1 percent is based on two factors: (1) most users stay off drugs while in treatment, and (2) some users stay off drugs after treatment.

The average cocaine treatment (a mixture of relatively inexpensive outpatient and relatively expensive residential treatments, including partial as well as complete treatments) costs $1,740 per person treated, so $34 million pays for 19,500 treatments. These additional treatments are assumed to be given to heavy cocaine users (of whom there are about 1.7 million today) with average use of about 120 grams of cocaine a year. The average treatment lasts 0.3 years, and 80 percent of people in treatment are off drugs, so the in-treatment effect of 19,500 treatments is about 5,000

person-years less heavy cocaine use, which amounts to 0.6 metric tons less cocaine consumption.

An estimated 13 percent of heavy users treated do not return to heavy use after treatment. Although not all those departures are permanent, during the 14 years following treatment, the 19,500 treatments would generate an estimated present value of 20,000 person-years less heavy cocaine use, which amounts to 2.4 metric tons less cocaine consumption. If we add the 0.6 metric ton in-treatment reduction to the 2.4 metric ton after-treatment reduction, we find that 19,500 additional treatments would reduce cocaine consumption by an amount equal to 1 percent of the 300 metric tons currently consumed annually.

The *specific* cost advantage of treatment over enforcement ($34 million as opposed to $246 million for domestic enforcement to achieve the same benefit) depends crucially on the estimated after-treatment effect. However, the cost advantage is so large that even if the after-treatment effect is ignored, treatment still is more cost-effective than enforcement. The in-treatment effect is one-fifth of the total, and five times $34 million is still less than $246 million.

Reducing the quantity of cocaine consumed is not the only possible measure of program effectiveness. However, our findings about the relative cost-effectiveness of the different control programs do not depend upon the choice of evaluation criteria. The cost-effectiveness ranking of the control programs studied here is the same whether one evaluates the programs in terms of their effects on consumption, the number of users, or societal costs of crime and lost productivity due to cocaine use. That is, in all cases, the supply-control programs are more costly than treatment programs per unit accomplishment (see Figure S.4).

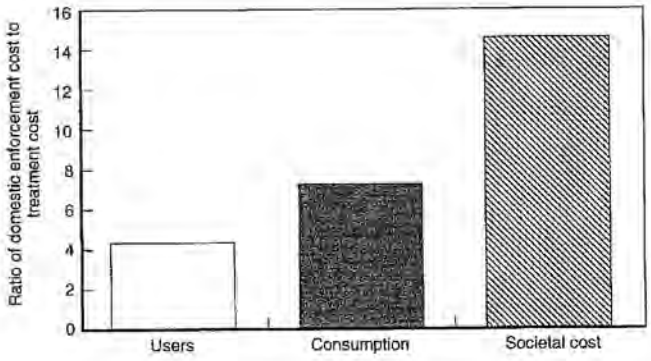


Figure S.4—Cost of Domestic Enforcement Relative to Treatment, for 1 Percent Reductions in Alternative Evaluation Criteria

The extent to which supply-control measures are more expensive, however, does vary depending on the evaluation measure chosen. Domestic enforcement costs 4 times as much as treatment for a given amount of user reduction, 7 times as much for consumption reduction, and 15 times as much for societal cost reduction.

These results suggest that if an additional dollar is going to be spent on drug control, it should be spent on treatment, not on a supply-control program. They do not, however, indicate whether or not that dollar should be spent in the first place. It might be that all four programs generate greater benefits than they cost, and treatment is just the best of four good programs. Or, at the other extreme, treatment might be merely the least ineffective of four ineffective programs.

With the first two criteria, quantity of cocaine consumed and number of users, this is as specific as one can get without placing a figure on the dollar value of reducing U.S. cocaine consumption by 1 metric ton or the number of users by 1,000. The benefits under the third criterion, reductions in the societal cost of crime and lost productivity, are, however, already measured in dollars. Hence, using this criterion, we can make some estimates of the four programs' absolute cost-effectiveness. The reader is cautioned, however, that societal costs are difficult to define, let alone measure; thus our estimates are very rough. Nevertheless, the results are intriguing.

This study found that the savings of supply-control programs are smaller than the control costs (an estimated 15 cents on the dollar for source-country control, 32 cents on the dollar for interdiction, and 52 cents on the dollar for domestic enforcement). In contrast, the savings of treatment programs are larger than the control costs; we estimate that the costs of crime and lost productivity are reduced by $7.46 for every dollar spent on treatment (see Figure S.5).

Our findings thus suggest a way to make cocaine control policy more cost-effective: Cut back on supply control and expand treatment of heavy users. In light of this conclusion, four (prominent) alternatives to current policy are explored this study:

- **Alternative A:** decrease each of the three supply-control program budgets by 25 percent.
- **Alternative B:** decrease the supply-control budgets by 25 percent and double the current treatment budget.
- **Alternative C:** decrease the supply-control budgets by 25 percent and treat 100 percent of heavy users each year.
- **Alternative D:** treat 100 percent of heavy users each year without changing the supply-control budget.

Our best estimates of the consequences of pursuing these alternatives to current policy are summarized in Figure S.6 and Table S.1. If supply-control budgets are cut by 25 percent (Alternative A), the cocaine problem (as measured by consumption) gets worse, but the supply-control cuts make the overall control budget decrease. However, spending about half of the supply-control savings on doubling treatment (Alternative B) reduces cocaine consumption below what would occur under current

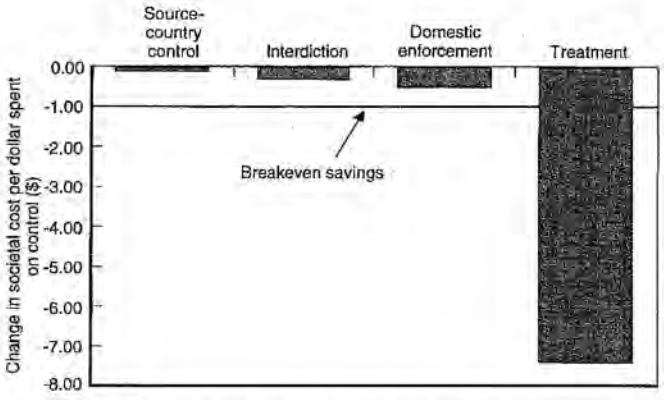


Figure S.5—Savings in Societal Costs of Crime and Lost Productivity Due to Cocaine Use per Dollar Spent on a Control Program

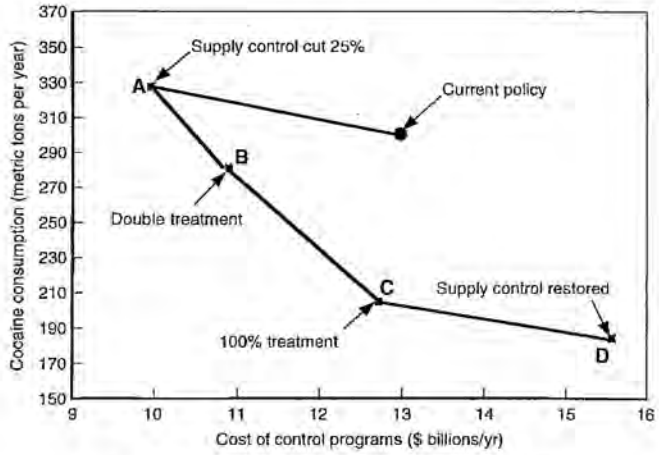


Figure S.6—Cocaine-Control Budget vs. Cocaine Consumption

Table S.1

Comparison of Alternative Composite Cocaine-Control Programs

		Evaluation Criterion			
Intervention Strategy	Total Control Cost ($ billions/yr)	Users (millions)	Consumption (metric tons/yr)	Societal Costs[a] ($ billions/yr)	Societal Cost plus Control Costs ($ billions/yr)
Current policy	13.0	7.06	314	29.0	42.0
Alternative A: Supply control – 25%	10.0	7.28	344	30.0	40.0
Alternative B: Double treatment	10.9	7.06	294	25.8	36.7
Alternative C: 100% treatment	12.7	6.67	211	19.0	31.7
Alternative D: Restore supply ctrl	15.6	6.42	188	18.3	33.9

NOTE: Alternative A cuts all three supply-control program budgets by 25 percent; Alternative B spends one-third of the supply-control savings on doubling the current treatment budget; Alternative C spends nearly all the supply-control savings to treat 100 percent of the heavy users each year; and Alternative D treats 100 percent of the heavy users each year with no cut in the supply-control budget. Estimates are annualized values over 15 projection years using a 4 percent real discount rate.

[a]Estimated cost of crime and lost productivity due to cocaine use.

policy. Expanding treatment to all heavy users (Alternative C) further reduces consumption and uses up essentially all the savings from the supply-control cut. Finally, if all heavy users are treated and the supply-control budget is not cut (Alternative D), consumption decreases even more, but the control budget is one-fifth higher than it is under current policy.

Decreasing supply control by 25 percent and doubling treatment (Alternative B) would leave the number of users essentially unchanged but would decrease average annual consumption by 20 metric tons (a 6 percent reduction). This composite program would save $2.1 billion in annual costs of cocaine control and $3.2 billion in annual societal costs, for a total annual saving of $5.3 billion.

Further expanding treatment to cover all heavy users (Alternative C) would decrease the number of users by 0.39 million and decrease average annual consumption by 103 metric tons, relative to current policy. The total annual cost of cocaine control would be only $0.3 billion less than under current policy, but societal costs would decrease by $10.0 billion, for total annual saving of $10.3 billion.

Finally, treating all heavy users without changing the current budget for supply control would decrease user counts, annual consumption, and societal costs even more. However, restoring the supply-control budget would increase control costs more than it would decrease societal costs, so the total annual saving relative to current policy, $8.1 billion, would be less than that under Alternative C.

Hence, this report concludes that treatment of heavy users is more cost-effective than supply-control programs. One might wonder how this squares with the (dubious) conventional wisdom that, with treatment, "nothing works." There are two explanations. First, evaluations of treatment typically measure the proportion of people who no longer use drugs at some point after completing treatment; they tend to underappreciate the benefits of keeping people off drugs while they are in treatment—roughly one-fifth of the consumption reduction generated by treatment ac-

crues during treatment. Second, about three-fifths of the users who start treatment stay in their program less than three months. Because such incomplete treatments do not substantially reduce consumption, they make treatment look weak by traditional criteria. However, they do not cost much, so they do not dilute the cost-effectiveness of completed treatments.

Does this mean that treatment is a panacea? Unfortunately not, because there is a limit on how much treatment can be done. In our analysis, we explore the consequences of treating every heavy user once each year (Alternatives C and D). In principle, even more treatment is possible because the average duration of a treatment is less than 12 months. However, considering the difficulties of getting people into treatment, more treatment may not be feasible. Treating all heavy users once each year would reduce U.S. consumption of cocaine by half in 2007, and by less than half in earlier years (see Figure S.7).

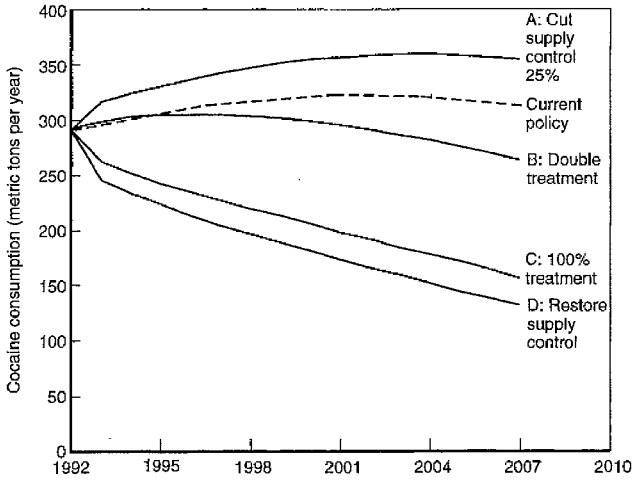


Figure S.7—Dynamics of Change in Cocaine Consumption

Mr. CONYERS. Mr. Chairman, can I congratulate you on starting our inquiry in this matter with Members of Congress who have some great and different experiences about this problem? And I thank you for starting it.

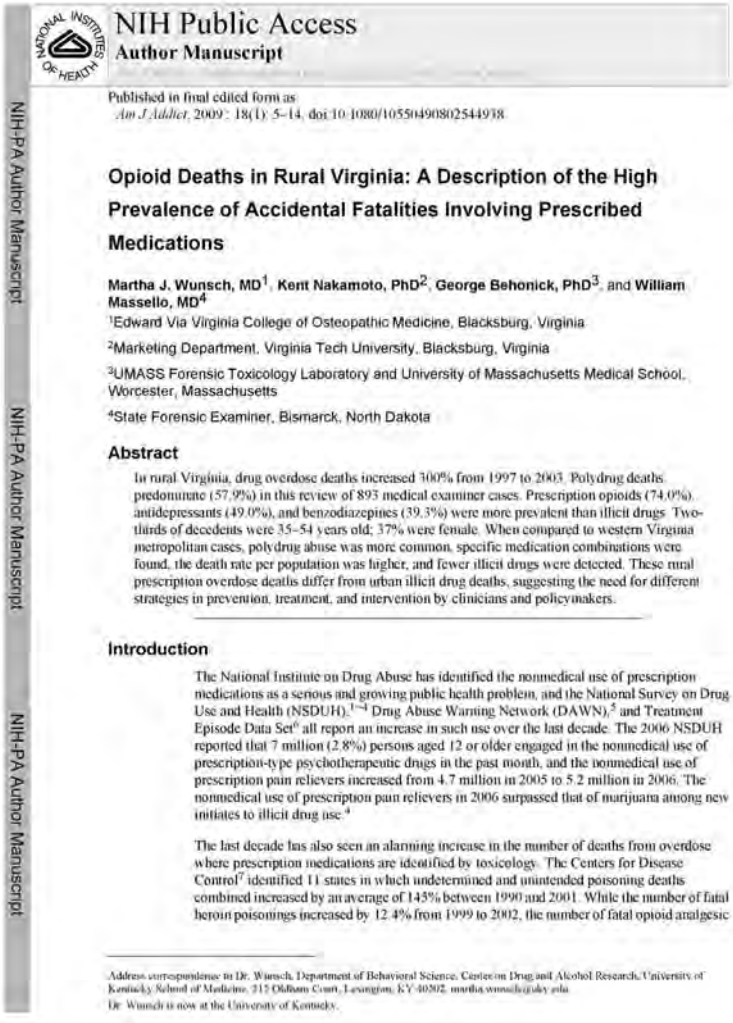
Mr. SENSENBRENNER. Well, I thank the Chairman emeritus. I am always happy to accept congratulations. They mean more from that side of the aisle than my own. [Laughter.]

So, again, thank you very much. And without objection, the Committee stands adjourned.

[Whereupon, at 10:36 a.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD



NIH Public Access
Author Manuscript

Published in final edited form as:
Am J Addict. 2009 ; 18(1): 5–14. doi:10.1080/10550490802544938.

Opioid Deaths in Rural Virginia: A Description of the High Prevalence of Accidental Fatalities Involving Prescribed Medications

Martha J. Wunsch, MD[1], **Kent Nakamoto, PhD**[2], **George Behonick, PhD**[3], and **William Massello, MD**[4]

[1]Edward Via Virginia College of Osteopathic Medicine, Blacksburg, Virginia

[2]Marketing Department, Virginia Tech University, Blacksburg, Virginia

[3]UMASS Forensic Toxicology Laboratory and University of Massachusetts Medical School, Worcester, Massachusetts

[4]State Forensic Examiner, Bismarck, North Dakota

Abstract

In rural Virginia, drug overdose deaths increased 300% from 1997 to 2003. Polydrug deaths predominate (57.9%) in this review of 893 medical examiner cases. Prescription opioids (74.0%), antidepressants (49.0%), and benzodiazepines (39.3%) were more prevalent than illicit drugs. Two-thirds of decedents were 35–54 years old; 37% were female. When compared to western Virginia metropolitan cases, polydrug abuse was more common, specific medication combinations were found, the death rate per population was higher, and fewer illicit drugs were detected. These rural prescription overdose deaths differ from urban illicit drug deaths, suggesting the need for different strategies in prevention, treatment, and intervention by clinicians and policymakers.

Introduction

The National Institute on Drug Abuse has identified the nonmedical use of prescription medications as a serious and growing public health problem, and the National Survey on Drug Use and Health (NSDUH),[1–4] Drug Abuse Warning Network (DAWN),[5] and Treatment Episode Data Set[6] all report an increase in such use over the last decade. The 2006 NSDUH reported that 7 million (2.8%) persons aged 12 or older engaged in the nonmedical use of prescription-type psychotherapeutic drugs in the past month, and the nonmedical use of prescription pain relievers increased from 4.7 million in 2005 to 5.2 million in 2006. The nonmedical use of prescription pain relievers in 2006 surpassed that of marijuana among new initiates to illicit drug use.[4]

The last decade has also seen an alarming increase in the number of deaths from overdose where prescription medications are identified by toxicology. The Centers for Disease Control[7] identified 11 states in which undetermined and unintended poisoning deaths combined increased by an average of 145% between 1990 and 2001. While the number of fatal heroin poisonings increased by 12.4% from 1999 to 2002, the number of fatal opioid analgesic

Address correspondence to Dr. Wunsch, Department of Behavioral Science, Center on Drug and Alcohol Research, University of Kentucky School of Medicine, 312 Oldham Court, Lexington, KY 40202. martha.wunsch@uky.edu
Dr. Wunsch is now at the University of Kentucky.

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

poisonings in the United States increased by 91.2%.[7] In 2003, DAWN (Medical Examiner) reported increased opioid-related drug deaths in Maine, New Hampshire, Vermont, Maryland, Utah, and New Mexico, involving predominantly the prescription medications oxycodone, hydrocodone, and methadone.[5]

Little is known about this newly emerging group of decedents other than their age at the time of death and the prescription medications identified by toxicology. More detailed description is needed to better understand the unique features of this problem. For example, it is curious that respondents reporting the nonmedical use of opioids to the NSDUH tend to be younger than victims in whom prescription opioid poisoning deaths are occurring.[1–3,7] Specifically, individuals aged 12–25 years old report the highest rates of nonmedical use of prescription drugs, while in five of the six states, the highest death rates were among adults aged 35–54 years old.

In order to examine the problem of prescription overdose fatalities in more detail, we studied drug overdose case records of the Office of the Chief Medical Examiner (OCME) in rural western Virginia, where the number of deaths involving prescription opioids increased rapidly between 1997 and 2003.[8,9] In this paper, we report the demographic characteristics of the decedents, the manner and assigned toxicological cause of death, and the medications and illicit drugs commonly present as identified by toxicology—notably, prescription opioids, benzodiazepines, and antidepressants. We then discuss the implications of these findings with respect to the rural populations, a group that displays an elevated risk for death from prescription opioids and combinations of opioids with other medications.

Materials and Methods

This retrospective, population-based review of medical examiner cases in the Office of the Medical Examiner (OCME), Western District of Virginia, began by identifying all cases classified as poisoning deaths occurring between the years 1997 and 2003. This time period coincides with a significant increase in drug overdose deaths, beginning with 67 drug deaths investigated by the OCME in 1997 and concluding with 223 drug deaths in 2003. The work is not intended to be an epidemiological study focused on population comparisons; rather, it is a comprehensive investigation into a set of clearly defined cases in which prescription medications were identified by toxicology. From an epidemiological perspective, our criterion for inclusion, any poisoning death in which a drug or drugs were a direct or contributing cause of death, may exclude some deaths involving indirect drug-related causes and thus underestimate the problem.

A medical examiner case is defined as including suspicious or violent deaths, unnatural deaths, or deaths related in the public interest such as incarcerated prisoners or patients in mental institutions. We selected all OCME Western District of Virginia cases categorized as poisoning deaths. We extracted the complete subset of drug deaths, which also included cases with prescription medications, classified as a direct or contributing cause of death. In the OCME, Western District of Virginia, when there is suspicion of drugs of abuse or poisoning in a death, a full autopsy is conducted, and specimens are obtained for toxicological analyses. After autopsy, the pathologists and toxicologists review cases to determine if and what additional toxicological examinations are required. If history and circumstances do not indicate that drugs are a cause of death, a limited toxicology is performed. In cases where there is a well-established cause of death, such as smoke inhalation, directed toxicological analysis for alcohol and other relevant substances (eg, carbon monoxide determinations) are conducted. All of the cases we reviewed included toxicological analyses, and all except one included an autopsy.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

The region served by the OCME, Western District, includes 34 counties and 16 municipalities, largely west of the Blue Ridge Mountains, with a population of 1.6 million people. This geographic area is inclusive of seven metropolitan statistical areas (Roanoke, Lynchburg, Blacksburg, Christiansburg, Radford, Harrisonburg and Danville) and two micropolitan statistical areas (Staunton-Waynesboro and Martinsville). No metropolitan area in western Virginia exceeds 100,000 in population; thus, even the metropolitan areas in this region are relatively small. The remainder of the region (classified rural) consists of 19 counties where no municipality exceeds 10,000 in population and six independent municipalities with populations less than 10,000.

U.S. Government Office of Management and Budget definitions and identifications of metropolitan and micropolitan areas were used to classify locations in which deaths occurred. Metropolitan statistical areas have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. Micropolitan statistical areas have at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. Metropolitan and micropolitan statistical areas are defined in terms of whole counties, or equivalent entities.[10]

Cases Reviewed

We reviewed 893 cases, excluding four cases in which decedents were children under the age of four years, resulting in a final case total of 889 deaths. We exclude the four cases because the manner and circumstances of poisoning in young children differs significantly from adults. The youngest case we included was 14 years of age. The information reviewed from the medical examiner files include autopsy reports, hospital records, physician notes, and records obtained by the OCME in death investigations, death scene reports, police reports of investigation including witness statements, and death certificates. Information was extracted from the decedent files by one research associate (RA). The first 100 files were entered simultaneously by both the RA and the PI (MW). Due to the objective nature of the data, interater reliability was nearly 100%. Only five discrepancies were noted in the 100 cases. The research team, including the forensic toxicologist (GB), forensic pathologist (WM), and statistician (KN), reviewed the dual entries to resolve discrepancies in data coding. In this manner, we assured accuracy and completeness in extraction and coding of the data. Throughout the remainder of the project, ten percent of the remaining files were chosen for review using a random number table; data were coded by both PI and RA, and reviewed by the research team for accuracy and completeness. The data were reviewed quarterly for completeness and accuracy by a multidisciplinary team, including a forensic toxicologist (GB), forensic pathologist (WM), and statistician (KN).

Decedent socio-demographic information, including date of birth, sex, race, and employment status, was extracted from death certificates. Toxicology data were available for all cases in our review and did not vary in level or source of testing, or by decedent year group. Quantitative analyses of drugs and drug metabolites in postmortem blood, body fluids, and tissues was performed by a number of validated analytical methods employing gas chromatography-mass spectrometry (GCMS), GCMS/selected ion monitoring (SIM), high-performance liquid chromatography (HPLC) with diode array or fluorescence detection, and gas chromatography (GC) with electron capture detection. The presence of drug(s) and drug metabolite(s) in body fluids (blood, urine, gastric fluid, bile, or liver), for each decedent, was coded as present or absent and, when concentrations were available, the information was included in the database. The presence of heroin was predicated on the identification of 6-acetyl morphine, the unique metabolite that distinguishes it from other opioids. Tests for the presence of this compound

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

were conducted in both blood and urine; while the half-life of 6 acetyl- morphine is short in blood, it is more stable in urine. Although the focus of the paper is prescription medications, several other common substances of abuse were identified by toxicology (alcohol, cocaine, tetrahydrocannabinoids, methamphetamine, and amphetamine) and were included for completeness.

Statistical Analysis

The data in this study are almost all nominal (categorical) variables. As such, the predominant analyses were in the form of cross tabulations; the chi-square test was used to test for statistical significance at or above the $p < .05$ level between variables or differences in distribution (eg, occurrence) among groups. Age and crude death rates were recorded or calculated as continuous variables (and means and standard deviations are reported); however, age groupings were constructed for subsequent analyses.

Results

Between 1997 and 2003, in rural western Virginia, the medical examiner's office reported a 300% increase in the number of deaths in which drugs, including prescription medications, were determined to be related or contributory to cause. Deaths in which drugs, including prescription medications, were either a direct or contributing cause of death increased steadily over the time period. Specifically, there were 65 drug deaths in 1997, 69 drug deaths in 1998, 83 drug deaths in 1999, 104 drug deaths in 2000, 163 drug deaths in 2001, 185 drug deaths in 2002, and 220 drug deaths in 2003. As shown schematically in Figure 1, the number of non-opioid deaths (cases of a drug-related nature, but exclusive for the absence of an opioid) averaged 29.3 per year and remained steady for the seven-year period ($\chi^2 = 3.76$, ns). However, deaths in which opioids were present by toxicology increased six-fold from 33 in 1997 to 184 in 2003 ($\chi^2 = 231.85$, $p < .001$). The highest proportion of deaths (568 of 889) occurred during the time interval 2001–2003.

Medications and drugs identified by toxicology in these cases are shown in Table 1. In the remainder of this analysis, we focus on three classes of medications that are present with high frequency in these decedents: opioids, benzodiazepines, and antidepressants.

Overall, in 57.9% of the cases, the cause of death involved more than one drug or medication; these are classified as polydrug deaths.

Prescription opioids were identified in 658 of the cases (74.0%). The most common prescription opioids identified were methadone (28.0%), hydrocodone (20.4%), and oxycodone (19.6%). 6-Acetylmorphine, the metabolic marker for heroin, was present in only 2.4% of cases.

Antidepressants were identified in 436 cases (49.0%). The most commonly identified include sertraline (22.7%), venlafaxine (20.8%), amitryptiline (9.8%), nortriptyline (9%), and citalopram (6.1%) or fluoxetine (6.1%).

Benzodiazepines were identified in 349 cases (39.3%). The most commonly identified were diazepam (24.3%) and alprazolam (15.4%).

As with heroin, other illicit drugs of abuse occurred with much lower frequency: cocaine 12.0%, THC 0.3%, methamphetamine or amphetamine 1.4 %. Alcohol was identified in 29% of the cases.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Demographics

Table 2 summarizes decedent demographics. The population of this region of rural western Virginia is predominantly Caucasian, with 50.8% of the population male, and 75% of the population ages 18–65 years old.[9] Among our cases, the majority of deaths occurred among males (63%) and Caucasians (96.8%). Female decedents were slightly older (female mean = 42.8 years, SD = 11.80; male mean = 38.5 years, SD = 10.40; $t = 5.60$, $p < .001$) and the greatest number of deaths (40.7% of women and 38.6% of men) occurred among individuals aged 36–45 years old. Most of the decedents had at least a high school education, with women more likely to have a trade, associate's degree, or a bachelor's or graduate degree ($p < .005$). A majority of the decedents were employed either part or full time (56.8%); men were more often unemployed or disabled ($p < .001$). The predominant manner of death was accident (78.9%); suicide accounted for 18.1% of cases. More female deaths were classified as suicide (female 38.3% vs. male 18.1%), while a higher proportion of male deaths were classified as accident (female 57.8% vs. male 78.9%; $p < .001$).

Location of Death by Population Density

Using census classifications of population, cases were stratified by location of death (Table 3). We defined a rural death as one in which the decedent's home address, as noted on the death certificate, was not in a micropolitan or metropolitan MSA. While less than half of the cases occurred among decedents whose home address was in a rural area (42%), the death rate, when adjusted for population density, was higher among decedents who resided in rural areas ($p < .05$). In addition, rural decedents differed from the metropolitan and micropolitan decedents in terms of drugs identified by toxicology. Polydrug toxicity as a cause of death was significantly more likely among rural decedents (61.6% vs. 55.2%; $p < .005$).

Location of Death and Drugs Detected by Toxicology

As noted above, overall in this group of decedent cases illicit drugs of abuse were found less often than prescription medications. Specifically, heroin was identified in only 2.4% and cocaine in 12% of the cases. When heroin was identified by toxicology, more often it was among decedents in micropolitan or metropolitan locations (3.3%) than rural areas (1.1%, $p < .05$). Likewise, cocaine was found among metropolitan/micropolitan decedents more often than among rural decedents (16.7% vs. 6.1%, $p < .001$).

In contrast, prescription opioids were more likely to be identified in rural areas than metropolitan/micropolitan (80.3% vs. 69.5%; $p < .001$). Of the six most frequently occurring opioids, three were more common in rural than in micropolitan or metropolitan areas—hydrocodone (29.1% vs. 14.0%, $p < .001$), oxycodone (24.8% vs. 15.8%; $p < .001$), and fentanyl (7.2% vs. 3.5%; $p < .05$). The occurrence of methadone (27.5% vs. 28.4%, NS) did not differ between rural and micropolitan or metropolitan areas. Benzodiazepines were more likely to be identified among rural decedents (45.1% vs. 35.0%, $p < .005$). However, there was no significant difference between rural and micropolitan or metropolitan areas in numbers of cases where antidepressants were identified (50.1% vs. 48.2%, NS).

Combinations of Substances

Polydrug toxicity was more likely than single drug toxicity to be the cause of death (57.9% vs. 36.2%; $\chi^2 = 44.5$, $p < .001$). In the remaining 5.9% of the cases, the deaths were classified by the medical examiner as drug deaths because of supporting toxicological identifications. For example, COD in a decedent could be hypothermia, however, prescription medications were identified by toxicology and also listed as contributory.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Single Drug Toxicity—In the 22.7% of cases of single drug opioid toxicity, methadone was most commonly identified by toxicology and assigned as cause of death. In the 3% of cases of single drug class benzodiazepine toxicity, diazepam was most commonly identified and assigned as cause of death. Although venlafaxine was the most commonly found antidepressant overall, in the 10.6% of cases of single drug antidepressant toxicity the cases were distributed across citalopram (six cases), fluoxetine (five cases), and doxepin (seven cases).

Figure 2 is a schematic illustrating the distribution of COD across medication classes. Because the majority of deaths were due to multiple medications, we examined differing combinations of drugs present in these cases.

Opioids and Other Drug Classes—Drugs from other pharmaceutical classes were also detected in combination with opioids. In particular, benzodiazepines and anti-depressants were frequently co-occurring. Figure 2 depicts the concomitant presence of opioids, benzodiazepines, and anti-depressants in these decedent cases.

Most notably, all three classes of pharmaceuticals were present in 151 decedent cases (19.0% of the deaths), and an opioid and one of the other classes were present in an additional 327 cases. Overall, 478 of the 658 cases positive for opioids (including heroin) had an anti-depressant, benzodiazepine, or both present.

Multiple Opioids—Table 4 illustrates the distribution of the number of opioids detected when one of the most commonly occurring opioids was also present. Of the 658 decedents in which opioids were identified by toxicology, one opioid was detected in 62.9% of cases, two opioids were detected in 26.6% of the cases, and three or more opioids were detected in 10.6% of cases. Methadone, when found by toxicology, was significantly more likely than other opioids to be the sole opioid identified ($p < .05$). Hydrocodone was most frequently found with one other opioid. Oxycodone was equally likely to be found alone or with one other opioid.

In contrast, in the 21 cases when 6-AM (heroin) was identified, decedents were more likely to combine it with prescription opioids. Specifically, in more than 60% of the cases where heroin was found, more than two prescription opioids were also detected, a pattern different than noted for other opioids ($p < .001$).

Combinations of Prescription Medications with a Prescription Opioid—Other medications identified by toxicology, given the identification of methadone, hydrocodone, or oxycodone, are listed in Table 5. As noted in the table, in many cases, decedents ingested other prescription medications and alcohol and cocaine. Of note, 21–29.7% of the time alcohol was present, while cocaine was identified 8–10.9% of the time. Additionally, sertraline and venlafaxine were present about 22.5–31.6% of the time regardless of the opioid found. A benzodiazepine was present in at least 19% of the cases; alprazolam was present in at least 19% of the cases, and diazepam present in nearly one-third of cases.

Discussion

Between 1997 and 2003, there was a 300% increase in drug deaths in western Virginia—an increase strongly associated with the presence of prescription medications by toxicology, with prescription opioids the most commonly identified drug class (74.0%). The findings of this review of decedent cases are consistent with national findings reporting an increase in poisoning deaths over the last decade.[7] They are also consistent with reports in which opioid analgesic deaths outnumber deaths when heroin is involved.[7,11,12] Thus, these decedent cases reflect what is currently known about prescription overdose deaths, and this review expands

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

our understanding of such drug overdose deaths by providing a level of detail not previously reported. Specifically, in this rural region:

- Older individuals, aged 35–45 years, represent the majority of the overdose cases, and women represent 37.1% of decedents. This is a group of decedents not previously identified at risk other than at an epidemiological level.
- Death rates are highest in rural areas, and prescription medications are much more likely to be found than illicit drugs of abuse.
- Polydrug deaths predominate, and we have identified the specific opioids, benzodiazepines, and antidepressants and combinations found on toxicology.

Older Individuals and Women

We might expect fatalities to be greatest among individuals using non-medically prescribed opioids, but this is not what we, or others, have reported. This group of decedents includes a disproportionate number of older individuals and women, a finding consistent with demographics reported nationally in prescription medication fatalities[3,7] and in New Mexico.[13,14] Consistently, epidemiological studies[2,3] state that adolescents and young adults (12–24 years old) are most likely to report drug abuse, and males who are 18–25-years-old report the highest rates of nonmedical prescription pain reliever use. Perhaps these epidemiological studies do not capture rates of nonmedical use of prescription medications among older people. Alternatively, it may be that the behavior that increases the risk of overdose and death is not what has been identified as nonmedical use. Although some use may have been for euphoria with diverted medications, some of the decedents may have had prescriptions for these medications, and inappropriate use, rather than behavior focused upon achieving euphoria (ie, abuse or addiction), led to overdose death. Therefore, use other than as prescribed by older individuals, which some authors have described as misuse,[15] may be a key factor in the increase in overdose deaths instead of abuse and addiction.

Rural Overdose Deaths

Although there are reports of increased numbers of prescription opioid deaths elsewhere in the nation,[5] our analysis allowed us to specifically focus upon rural prescription overdose deaths and highlight how they are different from urban deaths from the same cultural and political region of Virginia. Overall, this group of cases differs systematically from reports of illicit urban drug overdose deaths,[16,17] although in western Virginia, micropolitan and metropolitan decedents were more likely to die from abuse of heroin and cocaine. We have no explanation for the significantly higher death rate among rural cases; the prevalence of prescription opioids oxycodone, hydrocodone, and fentanyl; and the finding that benzodiazepines were more often identified among rural decedents. The similar prevalence of methadone equally among rural and urban decedents may be secondary to the lethality of this drug as a long-acting pharmaceutical. In this rural area, these decedents appear to have had access to prescription medications rather than heroin and cocaine, more available even in the smaller urban areas of western Virginia. Setting aside the issue of whether or not a decedent had a prescription for the medication listed as cause of death or whether the use is licit or illicit, interventions to prevent overdose deaths where a prescription medication is causal differ from those to prevent fatal overdoses where illegal drugs (ie, heroin and cocaine) predominate. In at least some of the cases, these medications were diverted from patients for whom they were prescribed, and in others, the fatal agent may have been prescribed to the decedent. In any case, the potential toxicity of these agents must be balanced with appropriate access for use as effective medications along with a clear message about safe use of medications with potential for overdose.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Our findings align with descriptions of the treatment needs of rural residents abusing and addicted to prescription medications. Perhaps adequate access to prescription medication addiction treatment, often a problem in rural areas, might have prevented some of these deaths. For example, among patients in rural New Hampshire, patients are less likely to abuse illicit substances, prescription opioids predominate as drugs of abuse, and patients may have been prescribed the drug they are abusing in addition to other prescription medications with abuse potential such as benzodiazepines.[18] The medications abused by these patients are similar to those that were fatal among rural decedents. Among 5,663 prescription opioid-dependent individuals admitted to methadone maintenance programs, Rosenblum reported that patients from low-density populated counties were more likely to abuse prescription opioids and were predominantly younger, employed women.[19] Similarly, among our decedents, women were more likely to be employed than men and have more education, as evidenced by a bachelor's degree, trade, or graduate degree.

Rosenblum proposes that the lack of availability of heroin in rural populations explains the predominance of prescription opioids abuse and addiction. There is also a dearth of heroin in rural Virginia; however, this would not explain the presence of multiple classes of prescription medications in the same decedent as well as deaths where antidepressant medications and benzodiazepines were identified. This would seem to have little to do with a lack of availability of heroin but might again indicate foci of effective treatment and targets for intervention to prevent diversion.

Prevalence of Polydrug Deaths

Rarely was the cause of death one drug, and in 151 cases, all three focal drug classes (opioids, benzodiazepines, and antidepressants) were detected. These patterns are consistent with those of other descriptions of polydrug overdose deaths[20–25] and indicate that this is a rather complex area in which to intervene, as there are multiple medications implicated in these deaths.

In our review, when hydrocodone or oxycodone was present, more than one opioid was found, indicating that, from whatever source, decedents have access to multiple opioids. When methadone was present, it was the sole opioid present in nearly 70% of the cases. Additionally, methadone was found more commonly among younger people age 14–25 years old. Because of the pharmacology of methadone and the potential for lethal overdose, we were not surprised that methadone was found often, and alone, in these drug deaths. Nonetheless, we suggest that the frequent presence of methadone as the sole opioids in young decedents should inform the interventions to prevent opioid overdose deaths. Particularly among older decedents, methadone was often combined with benzodiazepines and antidepressants. Again, some of these medications may not have been prescribed (eg, they were obtained by diversion), but these results emphasize the importance of educating patients to take medications only as directed, and not to share medications or combine medications.

Given the known potential for overdose secondary to respiratory suppression, we were not surprised to find significant numbers of cases where benzodiazepines and opioids were identified and that at least 20% of the cases alcohol was present with an opioid.[26,27] However, identification of substantial numbers of antidepressants on toxicology, and their association with opioids in 22% of overdoses, was of particular interest from a clinical and toxicological perspective. As has already been discussed, we do not know if antidepressants found were prescribed for the decedent; however, given the co-occurrence of depression and substance abuse, some of these decedents may have had prescriptions for antidepressants. Recent DAWN results emphasize the co-occurrence of depression and substance abuse as well as potential for overdose using prescribed medications. According to 2006 DAWN ED reports of drug-related visits, in 68% of mentions, the co-occurring disorder was depression, and over a third of the time, patients were diagnosed with an overdose.[28] Therefore, the identification of

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

antidepressants in these decedents suggests an area for intervention in prescribing patterns and patient education. There may be an overdose risk in the patient prescribed antidepressants, like the opioids and benzodiazepines, if they are not taken as prescribed, combined with other medications, or "shared" with others.

Investigation of the metabolic and toxicological implications of antidepressants, with particular emphasis on the drug-drug interactions and combinations present most often in overdose deaths, is a significant area of interest to forensic toxicologists and forensic pathologists. For example, several antidepressants in the SSRI and SNRI class (eg. fluoxetine, fluvoxamine, paroxetine, and sertraline) are capable of inhibiting, to varying degrees, CYP2D6 (primarily), CYP3A4, and CYP1A2 enzymes. The result is perturbation in the biotransformation of opioids resulting in increased blood concentrations of the drug and increased pharmacological effect and toxic side effects.[29]

These cases illustrate that it is not only younger people who are using prescription medications other than as prescribed. One of the factors increasing deaths where prescription medications are found, particularly opioids, may be use by individuals who are not the younger age group typically identified as abusing drugs and alcohol. For clinicians, the education of patients over age 35 years about appropriate use of prescribed medications may prevent overdose deaths in this population. When prescribing any psychoactive drug for any patient, clinicians must remind all patients that medications should be taken only as directed, should not be combined with other medications unless prescribed, and should be taken only by the patient for whom they are prescribed. In the case of opioid prescriptions, nonmedical use may be prevented by the use of Gourlay and Heit's Universal Precautions.[30] For patients with chronic non-malignant pain and a diagnosis of addiction, careful prescribing of opioids to prevent diversion is well outlined in guidelines proposed by Weaver and Schnoll.[31]

Limitations

There are inherent limitations in the study and characterization of a population where the cause of death is drug overdose. First, it is difficult to define the exact cause of death in cases with multiple or mixed drug intoxications. Postmortem toxicology is confronted by challenges such as anatomical sampling sites (eg. central or heart blood versus peripheral blood, such as femoral or iliac vessel blood), putrefactive and decompositional effects, postmortem redistribution of drugs, and the effects of drug tolerance and abstinence.[32] There are inherent difficulties in assigning causation.[20] Nonetheless, important findings emerged from our analysis. Second, classification for cause of death is determined by more than the presence or absence of a drug by toxicological analyses. Assignment of significance of each drug or drug metabolite may differ among toxicologists and forensic pathologists. We did not include concentrations of drugs or metabolites in this report because contribution to establishing causation without benefit of complete autopsy reports and the totality of each case's investigative information is limiting.

Comprehensive toxicological studies are directed by the nature and circumstances of the death. We are aware that some deaths in this region were not included in this analysis, as described in the methods section, and some decedent's cases were not included because of limited toxicology. Additionally, some of the medical examiner calls in the Western District of Virginia are initially investigated by local or field medical examiners and not referred for autopsy. Blood specimens collected undergo limited toxicological examinations, usually only for ethyl alcohol. Decedents in this group would not be included in the 889 cohort of cases we reviewed. We propose that exclusion of this data probably results in an underestimation of the problem, but in reality we have little information about the characteristics of those cases not included in our analysis.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Finally, the decedents we studied were from a specific geographic region, and so results may not generalize to other rural areas. However, our results are similar to those found in other primarily rural states across the nation and therefore should be of some utility in defining and addressing this emerging problem.[5]

Summary

Our in-depth study of overdose fatalities presents findings aligned with national epidemiological studies that describe increasing numbers nationwide of prescription medication overdose deaths, particularly among older individuals. In 889 drug overdose deaths from 1997–2003 among rural western Virginians, a predominance of prescription opioids, in combination with antidepressants and benzodiazepines on toxicology, is reported as a contributing cause of death rather than illicit drugs. Motivation for possession and use of these medications, treatment of a medical condition, or euphoria is unknown; however, these deaths have occurred disproportionately among an older population (age 35–45 years old), not the population described as engaging in nonmedical use in national surveys. Particularly among those rural decedents, illicit drugs were not often found in these deaths, suggesting that these decedents were not abusing or addicted to heroin or cocaine at the time of overdose. Interventions to prevent these deaths will involve, of course, identifying the rural individuals who are abusing or addicted to prescription medications and providing treatment that is focused upon those medications instead of upon primarily illicit drugs. In addition to the awareness about potential diversion and the nonmedical use of medications by youths, physicians should also be aware that an older population of patients (ie, patients 35-45-years-old) may be at risk. Given the identification of older decedents in our study and nationally, this population may not be taking these medications as directed or may be abusing or addicted to prescription medications, instead of illicit drugs. As policy makers and researchers formulate a response to the increase in non-medical use of prescription medications, an older population should be targeted for education as well as youths. We should educate all patients, and their families, about taking medication only as prescribed, only by the individual for whom is it intended, and the dangers of combining medications without prescriber knowledge.

Acknowledgments

Work on this project was supported by research grant #R03 DA019047-01A1 from the National Institute of Drug Abuse, Institutes of Health, Bethesda, Md. (Dr. Wunsch).

References

1. Substance Abuse and Mental Health Services Administration. Overview of findings from the 2003 National Survey on Drug Use and Health. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2004.
2. Substance Abuse and Mental Health Services Administration. Results from the 2004 National Survey on Drug Use and Health: National findings. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2005.
3. Substance Abuse and Mental Health Services Administration. Results from the 2005 National Survey on Drug Use and Health: National findings. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006.
4. Substance Abuse Mental Health Services Administration. Results from the 2006 National Survey on Drug Use and Health. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2007.
5. Substance Abuse and Mental Health Services Administration. The DAWN Report: Opiate-Related Drug Misuse Death in Six States: 2003. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2003.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

6. Substance Abuse and Mental Health Services Administration. Treatment Episode Data Set Highlights 2002. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2004.
7. Centers for Disease Control and Prevention. Unintentional and undetermined poisoning deaths—11 states, 1990–2001. MMWR Morb Mortal Wkly Rep 2004;53:233–238. [PubMed: 15041950]
8. Office of Management and Budget. OMB Bulletin No 07-01: Update of Statistical Area Definitions and Guidance on Their Uses. Washington, DC: OMB; 2006.
9. Paulozzi LJ, Budnitz DS, Xi Y. Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiol Drug Saf 2006;15:618–627. [PubMed: 16862602]
10. Wysowski DK. Surveillance of prescription drug-related mortality using death certificate data. Drug Saf 2007;30:533–540. [PubMed: 17536879]
11. Mueller MR, Shah NG, Landen MG. Unintentional prescription drug overdose deaths in New Mexico, 1994–2003. Am J Prev Med 2006;30:423–429. [PubMed: 16627130]
12. Shah NG, Lathrop SL, Reichard RR, Landen MG. Unintentional drug overdose death trends in New Mexico, USA, 1990–2005: Combinations of heroin, cocaine, prescription opioids and alcohol. Addiction 2008;103:126–136. [PubMed: 18028518]
13. Wunsch, MJ.; Boyd, CJ.; McMasters, MG. Nonmedical use of prescription medications. In: Ries, R.; F, D.; Miller, SC.; Saitz, R., editors. Principles of Addition Medicine. Vol. 4th. Philadelphia: Lippincott Williams & Wilkins; 2008.
14. Bryant WK, Galea S, Tracy M, Markham Piper T, Tardiff KJ, Vlahov D. Overdose deaths attributed to methadone and heroin in New York City, 1990–1998. Addiction 2004;99:846–854. [PubMed: 15200580]
15. Carson HJ. Classes of drugs and their prevalence in multiple drug intoxication in suicides and accidents. Leg Med (Tokyo) 2008;10:92–95. [PubMed: 17900964]
16. Signon SC. Characterizing the emerging population of prescription opioid abusers. Am J Addict 2006;15:208–212. [PubMed: 16923666]
17. Rosenblum A, Parrino M, Schnoll SH, et al. Prescription opioid abuse among enrollees into methadone maintenance treatment. Drug Alcohol Depend 2007;90:64–71. [PubMed: 17386981]
18. Cone EJ, Fant RV, Rohay JM, et al. Oxycodone involvement in drug abuse deaths. II. Evidence for toxic multiple drug-drug interactions. J Anal Toxicol 2004;28:616–624. [PubMed: 15516322]
19. Hull MJ, Juhascik M, Mazur T, Flomenbaum MA, Behonick GS. Fatalities associated with fentanyl and co-administered cocaine or opiates. J Forensic Sci 2007;52:1383–1388. [PubMed: 17944902]
20. Kuhlman JJ Jr, McCaulley R, Valouch TJ, Behonick GS. Fentanyl use, misuse, and abuse: A summary of 23 postmortem cases. J Anal Toxicol 2003;27:499–504. [PubMed: 14607006]
21. Wolf BC, Lavezzi WA, Sullivan LM, Flanagan LM. Methadone-related deaths in Palm Beach County. J Forensic Sci 2004;49:375–378. [PubMed: 15027564]
22. Wolf BC, Lavezzi WA, Sullivan LM, Flanagan LM. One hundred seventy-two deaths involving the use of oxycodone in Palm Beach County. J Forensic Sci 2005;50:192–195. [PubMed: 15831018]
23. Wolf BC, Lavezzi WA, Sullivan LM, Middleberg RA, Flanagan LM. Alprazolam-related deaths in Palm Beach County. Am J Forensic Med Pathol 2005;26:24–27. [PubMed: 15725773]
24. White JM, Irvine RJ. Mechanisms of fatal opioid overdose. Addiction 1999;94:961–972. [PubMed: 10707430]
25. Caplehorn JR, Drummer OH. Fatal methadone toxicity: Signs and circumstances, and the role of benzodiazepines. Aust N Z J Public Health 2002;26:358–362. [PubMed: 12233958]
26. Drug Abuse Warning Network. 2006: National Estimates of Drug Related Emergency Department Visits DAWN Series D-30, DHHS Publication No (SMA) 08-4339. Rockville, MD: 2008.
27. Leavitt, SB. Methadone-drug* interactions (*Medications, illicit drugs and other substances). Addiction Treatment Forum. [June 8, 2008]. Available at: http://www.atforum.com/SiteRoot/pages/addiction_resources/Drug_Interactions.pdf
28. Gourlay DL, Heit HA, Almahrezi A. Universal precautions in pain medicine: A rational approach to the treatment of chronic pain. Pain Med 2005;6:107–112. [PubMed: 15773874]
29. Weaver M, Schnoll SH. Addiction issues in prescribing opioids for chronic malignant pain. Journal of Addiction Medicine 2007;1:2–10.

30. Drummer OH. Postmortem toxicology of drugs of abuse. Forensic Sci Int 2004;142:101–113. [PubMed: 15172074]

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

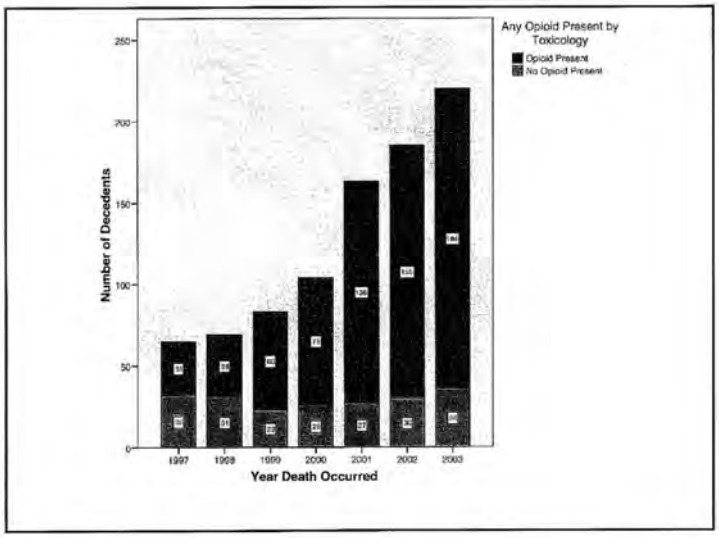


FIGURE 1.
Medical examiner drug-related deaths in Western Virginia. Figure 1 illustrates that the increase in overall drug-related deaths in western Virginia from 1997 to 2003 was primarily due to cases where an opioid was present on toxiology.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

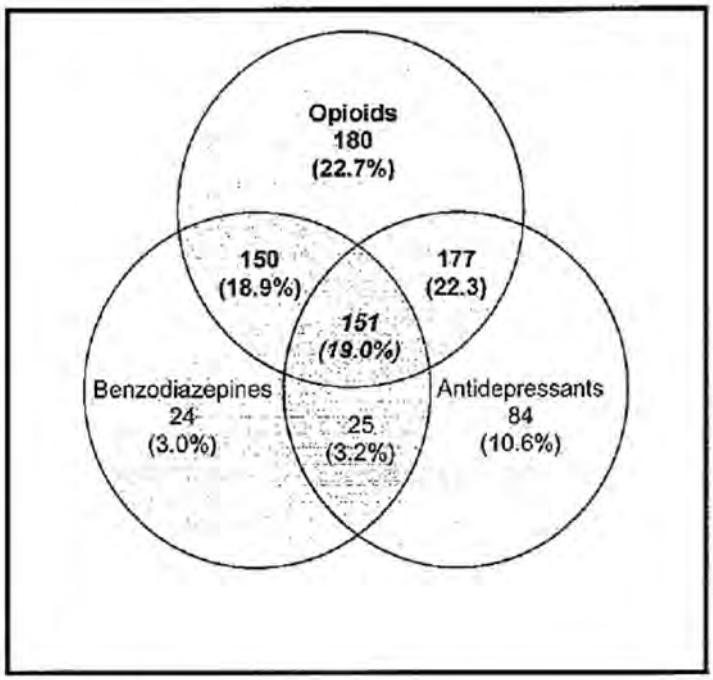


FIGURE 2.
Pharmaceutical classes found by toxicology (N = 793 cases; 96 cases with none of these three drug classes)

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

TABLE 1

Percentage of prescription medications and 6 AM (acetylmorphine) identified by toxicology

Opioids, benzodiazepines, and anti-depressants identified on toxicology (% of cases, N = 893)			
	Overall	Male	Female
Opioids			
Methadone	28.0	33.5	18.7
Hydrocodone[†]	20.4	19.8	21.5
Oxycodone[‡]	19.6	21.7	15.7
Morphine	11.4	12.1	10.0
Propoxyphene	9.8	9.6	10.3
Fentanyl[§]	5.1	4.6	5.7
Oxymorphone	3.7	4.6	2.1
Codeine	3.1	3.4	2.7
Tramadol	3.1	2.0	5.1
Hydromorphone	2.8	3.4	1.8
6-acetylmorphine[¶]	2.4	3.2	0.9
Meperidine	1.0	0.2	2.4
Dihydrocodeine	0.3	0.4	0.3
Pentazocine	0.2	0.0	0.6
Dihydrocodone	0.1	0.2	0.0
Hydrocodeine	0.1	0.2	0.0
Benzodiazepines[‖]			
Diazepam	24.3	25.6	21.8
Alprazolam	15.4	15.5	15.4
Clonazepam	1.5	1.6	1.2
Chlordiazepoxide	0.7	0.9	0.3
Temazepam	0.7	0.9	0.3
Lorazepam	0.4	0.4	0.6
Flurazepam	0.2	0.0	0.6
Oxazepam	0.2	0.2	0.3
Triazolam	0.1	0.0	0.3
Anti-depressants			
SSRI			
Sertraline	22.7	22.8	22.7
Citalopram	6.1	5.0	7.9
Fluoxetine	6.1	3.2	10.9
Paroxetine	2.7	2.1	3.6
Fluvoxamine	0.4	0.4	0.6
Tricyclics			
Amitriptyline	9.8	6.8	14.8
Nortriptyline	9.0	5.7	14.3
Doxepin	2.2	1.4	3.6

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Opioids, benzodiazepines, and anti-depressants identified on toxicology (% of cases, N = 893)

	Overall	Male	Female
Imipramine	0.8	0.2	1.8
Desipramine	0.7	0.2	1.5
Clomipramine	0.4	0.4	0.6
Amoxapine	0.1	0.0	0.3
Trimipramine	0.1	0.2	0.0
Tetracyclics			
Mirtazapine	4.6	4.8	4.2
Other			
Venlafaxine	20.8	21.2	19.9
Trazodone	3.7	1.8	6.9
Bupropion	2.1	1.6	3.0

This table describes the percentage of cases in which prescription medications were identified on toxicology in these medical examiner cases.

[a] Toxicological and chemical marker for heroin

[b] Identified more often in rural rather than micropolitan and metropolitan areas

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

TABLE 2

Demographic profile of decedents

	Number of cases (column %)			
	All	Female (37.1%)	Male (62.9%)	*p* value
Metropolitan	416 (46.8)	166 (50.3)	250 (44.7)	
Micropolitan	98 (11.0)	39 (11.8)	59 (10.6)	
Rural	375 (42.2)	125 (37.9)	250 (42.2)	
Race/ethnicity				.928
Non-Hispanic white	830 (96.8)	313 (94.8)	517 (93.5)	
African American	51 (2.5)	15 (4.5)	36 (6.5)	
Hispanic	2 (0.4)	0 (0.0)	2 (0.4)	
Native American	2 (0.4)	1 (0.4)	2 (0.4)	
Asian	1 (0.2)	0 (0.0)	1 (0.2)	
Age group (years)				<.001
10–25	98 (11.0)	27 (8.2)	71 (12.7)	
26–35	196 (22.0)	51 (15.5)	145 (25.9)	
36–45	361 (40.6)	145 (43.9)	216 (38.6)	
46–54	177 (19.9)	71 (21.5)	106 (19.0)	
55 or older	57 (6.4)	36 (10.9)	21 (3.8)	
Education				.005
High school	301 (34.8)	104 (32.9)	197 (35.9)	
High school diploma	386 (44.7)	124 (39.2)	262 (47.8)	
Trade/AS	118 (13.7)	58 (18.4)	60 (10.9)	
Bachelor's degree	42 (4.9)	21 (6.6)	21 (3.8)	
Graduate study	17 (2.0)	9 (2.8)	8 (1.5)	
Employment status				<.001
Employed	441 (56.8)	193 (65.4)	248 (51.5)	
Retired	23 (3.0)	10 (3.4)	13 (2.7)	
Disabled	206 (26.5)	59 (20.0)	147 (30.5)	
Unemployed	107 (13.8)	33 (11.2)	74 (15.4)	
Manner of death				<.001
Accident	631 (71.1)	190 (57.8)	441 (78.9)	
Suicide	227 (25.6)	126 (38.3)	101 (18.1)	
Undetermined	24 (2.7)	11 (3.3)	13 (2.3)	
Natural	6 (0.7)	2 (0.6)	4 (0.7)	

This table lists the location of death, demographics, education, employment status, and manner of death among medical examiner cases with stratification by gender.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

TABLE 3

Location of decedent cases by population density

Population density	Decedent cases (%)	Population (2000 census)	Annual deaths per 100,000 (crude) (α = .95)	
Metropolitan (MSA)	420 (46.8%)	886,546	6.77	(6.12,7.42)
Micropolitan	98 (11.0%)	182,334	7.68	(6.16,9.20)
Rural	375 (42.2%)	497,725	10.76	(9.67,11.85)

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

TABLE 4

Number of opioids found in presence of specific opioids

Opioid present by toxicology	No other opioids identified by toxicology	Only one other opioid identified toxicology	Two or more other opioids identified by toxicology
Methadone	69.9%	22.1%	8.0%
Oxycodone	37.9%	37.9%	24.1%
Hydrocodone	27.6%	44.8%	27.6%
Heroin (6-AM)	None*	38.1%	61.9%

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

TABLE 5

Other drugs present on toxicology when methadone, hydrocodone, or oxycodone were detected (% of positive cases)

	Reference opioid present on toxicology		
	Methadone	Hydrocodone	Oxycodone
Number of cases	250	182	174
Other substance present			
Opioids			
Fentanyl	1.6	7.1	5.2
Hydrocodone	13.2		31.6
Hydromorphone	1.2	8.8	2.9
Methadone		18.1	14.4
Morphine	3.6	6.6	7.5
Oxycodone	10.0	30.2	
Oxymorphone	0.8	7.1	19.0
Propoxyphene	6.4	15.4	8.0
Tramadol	0.4	5.5	1.7
Benzodiazepines			
Alprazolam	19.2	23.1	18.4
Diazepam	32.8	26.9	32.2
Anti-depressants			
Sertraline	25.6	25.1	32.2
Amitriptyline	8.0	12.6	8.6
Nortriptyline	6.8	11.5	6.3
Venlafaxine	23.6	22.5	31.6
Other substances			
Cocaine	10.4	8.2	10.9
Ethanol	21.6	29.7	26.4

Ameritox℠
Medication Monitoring Solutions

Statement for the Record Submitted on Behalf of Ameritox, Inc.

United States House of Representatives Committee on the Judiciary

Subcommittee on Crime, Terrorism, and Homeland Security

Hearing on "The Prescription Drug Epidemic in America"

March 7, 2012

Ameritox, Inc. (Ameritox) appreciates the opportunity to submit this written statement for the record of the Subcommittee's hearing, entitled "The Prescription Drug Epidemic in America." Ameritox applauds the Subcommittee's Leadership and Members for their efforts to focus public attention on this serious and growing problem and to identify potential solutions.

Millions of Americans suffer from debilitating chronic pain, and appropriate use of pain medications provides patients with the relief they need to lead productive lives. However, the legitimate use of long-term pain medication is undermined by the possibility of addiction, substance abuse, diversion of medications, and overdose leading to coma and/or death. According to the Office of National Drug Control Policy (ONDCP), prescription pain medication abuse is now the second most common illegal drug problem in the nation. In 2010, more Americans died from misuse of prescription opioids than from heroin and cocaine combined.[1] Additionally, from 1999 to 2006, hospitalizations for poisoning by prescription opioids, sedatives, and tranquilizers increased by 65 percent.[2]

A major component of assuring quality of care for chronic pain is appropriate management of opioids and other controlled drugs. Unfortunately, drug misuse, abuse, and diversion are major health and economic problems that have not been effectively addressed. According to a report by the Substance Abuse and Mental Health Services Administration (SAMHSA), there has been alarming growth in the non-medical use of prescription pain medications in recent years. The non-medical use of prescription pain-relievers is now the second most prevalent form of illicit drug use in our nation.[3]

Physicians need sophisticated tools to help confront this problem and to ensure that their patients are taking their medication appropriately. Medication monitoring, using periodic urine testing provides physicians with critical insights into the use of pain medication, as well as identifying other legal and illegal drugs possibly being used by their patients. As the nation's leader in performing

---

[1] Centers for Disease Control and Prevention, July 2010, Unintentional Drug Poisoning in the United States Available at www.cdec.gov/home and recreation safety/poisoning.

[2] Coben, J.H. *et. al.* (2010) Hospitalization for poisoning opioids, sedatives, and tranquilizers. *American Journal of Preventive Medicine*, 38(5), 517-524.

[3] Substance Abuse and Mental Health Services Administration, February 2009, The National Survey on Drug Use and Health Report, Available at http://www.oas.samhsa.gov/2k9/painRelievers/nonmedicalTrends.pdf.

medication monitoring tests, Ameritox has considerable expertise utilizing advanced clinical laboratory technologies, which hold significant potential to address the problem of diversion.

Medication monitoring testing is an established standard of care for chronic pain patients on opioid therapy and is endorsed by multiple professional societies (*e.g.,* the American Pain Society and the American Academy of Pain Medicine), the Department of Defense, and the Veterans Health System. In addition, State laws in Utah, Louisiana, and Washington support periodic urine drug monitoring as a standard of care for patients receiving chronic opioid therapy.

Expert guidelines and state regulations are based on research that shows that physicians cannot reliably assess the potential for their pain patients to be misusing, abusing, or diverting controlled drugs. A study from Brigham and Women's Hospital, published in the *Clinical Journal of Pain* in 2002, demonstrated that physicians miss at least 30 percent of cases of patients taking illicit or non-prescribed controlled drugs (verified by urine drug testing) when they used clinical judgment alone.[4]

Physicians routinely use urine-based laboratory medication monitoring tests as part of the management of chronic patients to ensure that patients are receiving the prescribed regimen of medications, taking their medication as directed, gaining positive outcomes, and not diverting their medication for other uses. These tests are performed in sophisticated laboratories and provide crucial information to physicians who order these tests.

There is also evidence that medication monitoring is a cost-effective solution that reduces treatment costs while improving quality of care. A recent study published in the *American Journal of Managed Care* analyzed the prevalence and cost of chronic opioid therapy, as well as the economic impact of compliance with pain medication.

The study demonstrated that the average total annual medical spending for patients on chronic opioid therapy was over $23,000 per year (2008 dollars). Patients who were adherent to their opioid regimen had costs that were approximately $3,400 (12%) per year lower than non-adherent patients. In addition, patients with normalized urine drug levels either above or below the expected range had significantly higher annual health care costs.[5]

Further, medication monitoring helps physicians identify potential interactions with other legal prescription medications and over-the-counter remedies. Thus, it saves the health care system millions of dollars every year in unnecessary hospital admissions due to drug poisonings from the use of multiple medications.

In conclusion, Ameritox strongly supports the Subcommittee's efforts to highlight the growing problem of prescription drug abuse and to identify potential solutions. Ameritox believes that medication monitoring tests are an important tool to prevent such abuse and would welcome the opportunity to serve as a resource to federal policy-makers.

---

[4] Katz N, Fanciullo G, et al. The role of urine toxicology testing in the management of chronic opioid therapy. *Clinical Journal of Pain.* 2002;18;S76-82.

[5] Leider HL. Healthcare costs and nonadherence among chronic opioid users. *Am J Manag Care.* 2011;17(1):32-40.

Thank you for your consideration of our views, and please feel free to contact us for any additional information that may be helpful to the Subcommittee.

Sincerely,

Harry Leider MD, MBA, FACPE,
Chief Medical Officer and Senior Vice President
Ameritox, Inc.

Prepared Statement of Anne McGee, Director,
Cabell County Substance Abuse Prevention Partnership

My name is Anne McGee and I have been the director of the Cabell County Substance Abuse Prevention Partnership, a coalition of concerned individuals, agencies and organizations for the past six years. We are located in my hometown of Huntington, WV which is located on the Ohio River and borders Kentucky and Ohio. The single biggest change in my hometown, in my lifetime, has been the devastation wrought by the "drug problem." When the Cabell County Substance Abuse Prevention Partnership was founded in 2006, we thought that crack cocaine being brought in from Detroit was the main problem. As we gathered data and studied the problem, we learned that crack may be the drug that garnered the headlines and the attention of law enforcement, but far more disturbing and pervasive was the non-medical use of prescription drugs. Our teenagers were reporting increasing use of prescription drugs; the lines at the for profit methadone clinic every morning were out the door; drug overdose fatalities were reaching record highs; obstetricians were reporting more addicted patients; and reports of drug seekers in the emergency rooms were a daily occurrence.

In 2007, we held a roundtable discussion for healthcare providers to discuss the data we had gathered regarding prescription drug abuse. The consensus from those in that earliest discussion was that the overprescribing of prescription pain relievers and benzodiazepines by the local medical community was a major part of the problem. We followed up with a community wide drug summit where we included all sectors of the community. We learned that not only was overprescribing a problem, but it was far more complicated: prescription drugs and the selling of those drugs by the patient on the black-market was supplementing the incomes of many living on fixed incomes; that patients have unrealistic pain expectations and demand and expect pain free recuperation from injury or surgery; that the Appalachian culture promotes and supports the sharing of prescription drugs among friends and family. And that our children were diverting medications prescribed to the adults in their lives for both medical and non-medical purposes. Our schools reported that many of the expulsion hearings were for students caught bringing prescription drugs to school. Local property crime rates were increasing throughout the county and copper and other metal thefts were rampant. Then the Journal of American Medical Association published the findings of a CDC study showing WV had the highest death rates in the nation for prescription drug overdose. Fatality rates began to skyrocket across the nation with WV leading the charge with greatest number of fatalities and Cabell County having some of the highest mortality rates in the state.

As we focused on our youth, we realized there were no evidenced based strategies or programs that focused on preventing prescription drug abuse, we also knew from community readiness assessments that the community as a whole had little or no awareness of the growing prescription drug abuse problem, unless and until it struck too close to home. We took the lessons learned in preventing youth use of other legal drugs like alcohol and tobacco and we started with general awareness strategies combined with attempts to limit youth access to prescription drugs.

We recruited a few physicians to our cause and they drafted a letter on the coalition's behalf to every healthcare provider with prescribing privileges in Cabell County, sharing our data and urging and encouraging the use of the WV Board of Pharmacy Controlled Substances Monitoring Database. We conducted awareness presentations throughout the community. We offered trainings to nurses, teachers, coaches, parents and grandparents. We conducted social marketing campaigns and held dozens of public forums and summits; and we recruited volunteers and coalition members along the way. We have involved the media in every one of our efforts and we have seen community readiness increase and a slight decrease in the percentage of students reporting the non-medical use of prescription drugs.

Knowing that limiting access is a key strategy in reducing youth substance use, we have sponsored and promoted prescription take back events collecting over 500 pounds of unwanted medications in the past year. We have partnered with the local hospital to provide information to local senior citizens regarding medication safeguarding and disposal. We have sponsored programs for the local medical society and we have talked to every elected official who will listen.

Prescription drug abuse is destroying southern West Virginia. The statistics and data support the severity of the problem. Unlike illegal drugs, prescription drugs are subject to regulation and control. Community efforts like the Cabell County Substance Abuse Prevention Partnership can only do so much in reducing the abuse and misuse of these substances. We need stronger and better controls over controlled substances. We are losing our children, our work force, and our quality of life to an epidemic that is 100% preventable.

PRESCRIPTION DRUG PROBLEMS PLAGUE SOUTHERN WEST VIRGINIA

"How communities are living (and fixing) these problems!"

Presented by…

Greg Puckett
Executive Director
Community Connections, Inc.
215 South Walker Street, Princeton, WV 24740
Phone: (304) 913-4956 – Fax: (304) 913-4964
Email: drugfree@strongcommunities.org
Website: www.strongcommunities.org

PRESCRIPTION DRUG PROBLEMS PLAGUE SOUTHERN WEST VIRGINIA

"How communities are living (and fixing) these problems!"

Nestled in the heart of the Appalachia, West Virginia is known for its breathtaking scenery, natural wonders, and historical significance. It is also known for its people; hard working, caring and giving. Our communities, both large and small, and those families within them, are a collection of contrasting styles and tradition. From our Ohio River towns on the northeastern side of the state, to the isolated mountain ridges to the east, our state is a plethora of geographical and cultural diversity found nowhere else in the United States.

This is particularly evident in the southern seventeen counties that lie in the third Congressional District (Rahall –WV 3rd). From greater metropolitan Huntington area to the southern coalfields to the south, this area is deeply rooted in family and cultural norms that date back generations. Traversing the country roads from west to east, the state transforms from the harsh topography and economic hardships of the coal towns, into a series of rolling hills and farming communities, eventually giving way to the western ridges of the Shenandoah Mountains.

Our people, our land, our resources... All are amazing qualities that define who we are and how we live. We are a proud, giving culture that would give much of themselves to help the greater well-being of others. Perhaps this is but one of the many reasons why we have seen a problem like we have never seen before become so bad, so fast...

Prescription Drug Abuse.

The problem

With high teen pregnancy, drop-out rates, juvenile delinquency, family violence, and drug and alcohol abuse, many of West Virginia's youth are left with little opportunity for a healthy and secure future. As automation has replaced manpower, the population is continually struggling to overcome the economic collapse. Hardships are increasingly becoming the norm and increasing poverty levels have taken a high toll on our entire state. These hardships have also increased the number of families in the coverage area to depend on government assistance to meet their family's needs. These dire circumstances have lead many youth into experimenting with substances (including alcohol, tobacco, and prescription drugs), early sexual behavior, driving under the influence of alcohol, and other harmful behaviors. Youth also tend to have a stronger mindset towards various 'rites of passages' – including those with negative results.

In the last ten years, our nation has been plagued with a tragic increase in deaths and overdoses from prescription drugs – largely fueled by a rise in consumption of prescription painkillers, or "opioids." From 1997 to 2007, the use of prescription opioids in the United States has increased 402 percent. Death rates involving opioids have more than tripled in the United States in the past decade, exceeding deaths from heroin and cocaine overdoses combined.

In 2005-2006, West Virginia exceeded the national rate on self-reported use of "nonmedical use of pain relievers in the past year" in all age groups, particularly 18 to 25 year olds. Nearly 90% of nonmedical users of prescription-type psychotherapeutic drugs reported getting the most recently used drug from a friend or relative or just one doctor (2007). Between 1999 and 2004, West Virginia had a 550% increase in unintentional poisoning deaths. **This is more than double any other state**. Of these unintentional poisoning deaths, approximately 97% involved drugs or alcohol rather than other substances. In 2006, there were 295 fatal overdoses in the state; prescription pain medication contributed to 93% of these deaths.

The major risk factors that contribute to risky behaviors among our youth in the targeted communities include: poverty, abuse and neglect, weak social ties (rural isolation), poor school performance, favorable attitudes toward problem behaviors (alcohol, tobacco and other drug use, violence, school dropout, and teen pregnancy) and availability of alcohol, tobacco, and other drugs. The main protective factors for our youth that have been identified are 'religiosity' and attachment to family and community.

In fact, within West Virginia...

- It is estimated that 152,000 West Virginians over the age of 18 have a substance abuse problem.
- The percentage of women smoking in West Virginia during pregnancy in 2009 was 27.3 percent compared to 23.6 percent of the general population of women who smoke in West Virginia. There were almost 8,000 illicit drug arrests in West Virginia in 2009.
- Opiates are the number one cause of death associated with drug overdoses in West Virginia. Overdose deaths from 1999-2004 increased by 550 percent.
- Drug overdose is the leading cause of death for West Virginians under the age of 45.
- The state ranks highest in the nation for retail prescription drugs filled at pharmacies (over 20 prescriptions per capita).
- More than 70 percent of people who abused prescription pain relievers received them from friends or relatives; five percent obtained them from a drug dealer or from the Internet.
- A 2009 umbilical cord study in eight West Virginia hospitals concluded that almost 20 percent of babies tested had been exposed to drugs. Anew 2010 study revealed that this number had increased in one hospital to 33 percent, compared to a national average of four percent.

The 2009 CASA publication examined the cost of substance abuse on budgets. The report found the following significant costs: in state public programs, 18% of budgets are linked to substance abuse and addiction; states spend 113 times as much to clean up the devastation substance abuse and addiction cause children as they do to prevent and treat it; and of every dollar states spent, $0.96 went to shoveling up the wreckage of substance abuse and only $0.04 was used to prevent and treat it. The report also found that the most significant opportunity to reduce the burden of substance abuse on public programs and ultimately, on **taxpayers** **is through targeted and effective prevention programs.**

Fixing the problem

Since the mid 1990's, there have been multiple community based organizations throughout the state working to change communities for the better. "Family Resource Networks" have continually identified needs within the communities in which they served and worked to secure funds to change the norm. These organizations and partners within these communities have been working diligently to unify their message and work cooperatively to leverage existing resources. This community based approach works well within West Virginia.

Just in the past five years, these networks have modified their outreach to become a more comprehensive community anti-drug coalition effort. This movement within the state has changed the ways communities view substance abuse and ways to combat the problems associated with it. Throughout West Virginia, people are focused around getting more engagement from those paying for substance abuse and training them to deliver the appropriate response; increasing the capacity of community prevention coalitions by providing them with leadership and using data-driven prevention strategies to address the local/community needs and focuses, along with addressing state and national level priorities.

Many counties have worked to develop coalitions in the past. Currently there are eight SAMHSA (Substance Abuse and Mental Health Services Administration) Drug Free Community Support Program grantees that exist in West Virginia. Those are Jackson, Marshall, Morgan, Brooke, Mingo, Cabell, Mercer, and Ohio counties. Although there are only eight DFC coalitions in the state, there are forty two more that have membership with the West Virginia CADCA (Community Anti-Drug Coalitions of America) Association. And now, thanks to the strategic prevention framework process within the past years, many coalitions throughout the state are working to leverage their funding and resources to create new initiatives, resulting in a more cohesive environment for cultural change in preventing substance abuse.

In addition, just in the past two years, the West Virginia Bureau for Behavioral Health and Health Facilities has restructured its dissemination of the Federal Substance Abuse Prevention and Treatment Block Grant funds to channel monies to communities across the state to unify these prevention and treatment efforts. And just recently in 2011, Governor Earl Ray Tomblin signed an Executive Order creating a Substance Abuse Advisory Council to:

- Provide guidance regarding the implementation of the approved Statewide Substance
- Abuse Strategic Action Plan.
- Identify planning opportunities with other interrelated systems to increase both public and private support concerning substance abuse initiatives.
- Recommend a list of priorities for the improvement of the substance abuse continuum of care.
- Receive input from local communities throughout West Virginia; and
- Provide recommendations to the Governor.

In coordination with the Governor's office and with key stakeholders and with the support from our federal, state and local partners, the Bureau for Behavioral Health and Health Facilities, along with the other bureaus of the West Virginia Department of Health and Human Resources, will continue to proceed with the implementation of the Comprehensive Substance Abuse Strategic Action plan to provide a clear direction to this epidemic. Regional task teams will continue to meet monthly to develop

strategies to address problems unique to their particular area. In doing this, we will continue to provide the opportunity for West Virginians to regain a sense of hope that seems to have been lost by so many during these challenging times.

Link to Governor's comprehensive Substance Abuse Plan
http://governorssubstanceabusetaskforcewv.com/images/Resources/2358_SubStrategicActionPlan_6PG_rev110711.pdf

It is proven that Governments can reduce their costs linked to abuse of alcohol, drugs and tobacco by adopting strategies to prevent and eliminate, and not just manage the consequences of substance abuse. Using these strategies to deliver prevention activities that would prevent and/or eliminate substance abuse among youth within the coverage area has the potential to save millions of dollars. Cohen (1998) found that if one young person can graduate, stay away from alcohol, tobacco and other drugs, and live crime free then there is potentially $1.7-2.3 million saved by society.

Community Coalitions uniquely work with communities to fill a major gap in the services available to our youth and their families, and is a critical component of our drug and crime prevention and workforce development efforts. Research has shown that preventing disease and injury costs less than treating them. It is estimated that there is at least $10 is saved for every $1 spent on evidence based prevention.

While funds are grossly inadequate to deal with the magnitude of the prescription drug abuse problem, they are better equipped to think strategically and develop action plans that support the long term growth and development of our county's healthcare and human service infrastructure. Simultaneously, by working together with others, the goal is to reduce drug use and crime within the community, and ultimately contribute to significant cost savings for local, state, federal governments and the United States tax payers.

Throughout the past few years, prescription drug abuse has become a massively detrimental problem on the society of all West Virginians. Through research, we have discovered that this the fastest growing segment for illegal drug use, and more people abuse prescription drugs than the number of people who use cocaine, methamphetamine, and heroin **combined**. In five years (1999-2004), deaths resulting from drug overdose in West Virginia rose 550%. This was the largest increase of any state in the country and more local data suggests that this has risen at an even greater rate since that time. These statistics, combined with an increasing elderly population, declining economy, and easy access to the drugs, leaves the southern part of the state particularly vulnerable to future problems. This, in turn, stresses the dire need for an adequate continuum of care system that encompasses quality prevention, early intervention, treatment and recovery systems that are funded at their highest possible levels. Only then, can we turn the corner on this deadly epidemic.

For generations the workforce within West Virginia has been seen as a committed, strong, viable, productive group of people 'willing to work until the job is done'. This is now in jeopardy. With the rising problems associated with the disease of addiction, many businesses are wondering how they can provide quality products and services without having a workforce that can't pass a drug test. This leaves

not only existing businesses with additional liability and potentially sub-par performance, but sends the wrong message to potential businesses that could perhaps look to our state for future opportunities.

If we are to fix these issues, we must internally reinvest in how we deal with the problems associated with drug abuse. Communities across the state are working together to address these issues though local community based coalitions, health and treatment centers, increased law enforcement, local civic and social groups and so much more. These organizations are willing to invest their time and resources towards fixing the problems where they exist most...at the community level. They have received specialized training and have gained expertise in knowing how to implement effective environmental change approaches in dealing with these issues, but only few possess the funds necessary for long term success. Many of these agencies spend much of their time focused on where the next source of funding will come from instead of truly dealing with the problem head on. Research has shown that for every dollar spent in prevention at the community level; nearly $21 is saved in long term detrimental effects to society.

Therefore, in closing, sustainable funding for prevention based initiatives, that are effectively followed by a comprehensive continuum of care system, should be supported at the maximum level possible as quickly as possible. The prescription drug abuse problem that West Virginians face did not occur overnight and the solutions will take time. The Bureau for Behavioral Health and Health Facilities (the state management agency for the Substance Abuse Prevention and Treatment (SAPT) Federal Block Grant), has worked throughout the continuum of care and is dedicated to oversight of this problem within the state. Through their support, all prevention, early intervention, treatment and recovery systems are now working together to make a difference but much like a business looking to gain a customer base, a great deal of monies must be spent on the front end to achieve a long term sustainable effort. The appropriate funding, combined with proven effective, evidence based strategies, will swiftly impact the problems head on and empower communities to battle this disease. The fight against drug abuse is not an easy one, but one we must win."

OUR STORIES...

Debbie Williams
Raleigh County Family Resource Network

"When I was trying to find a place to have the Take Back Day activities (in cooperation with the Drug Enforcement Administration's National Take Back Day program), I checked with Sam's Club to see about having it on their parking lot. I spoke with the clerk at the service desk and explained to her what I wanted. She began to get excited and said to me that, "It's about time someone tried to do something about the prescription drug problem. She went on to say that her son was 17 and was addicted to prescription drugs, and that she was having a terrible time trying to find help for him; that there was nowhere to send him for help in West Virginia; and that West Virginia needed a facility for teens who were addicted to prescription drugs.

I asked her how did he got addicted, and was there someone sick in her home. She looked at me in disbelief and said to me, "Are you kidding? They are on the streets! They can get them anywhere, and they go for as much as $5.00 to $50.00 or more a pill." She said that we really needed to clean up the streets from prescription drugs.

As a mother and grandmother, I did not know that this problem was so strong among our teens. We do have work to do."

.....

Aletha Stoler
Fayette County Family Resource Network / Substance Abuse Task Force

"I became aware of prescription drug abuse over three years ago through conversations at the Fayette County Family Resource Network monthly community meetings. The effects were felt in community corrections (Day Report Center), education (truancy), removal of children from the home (Child Protective Services), and so many other venues. In response to these pressing community needs, we created a Substance Abuse Task Force. Activities included holding 50 community forums about this issue (with assistance from the WV Center for Civic Life), initiating a substance abuse prevention education program (Reality Tour) for caring adults and youth, and getting the ADAPT program (intensive outpatient therapy program for youth administrated by FMRS) re-instituted in Fayette County; and more initiatives.

Through this work, I've heard many stories from families, friends, and individuals regarding their experiences with substance abuse - particularly prescription drug abuse. The recurring theme in these narrations was a legitimate injury requiring legal pain medications and then a progression of addiction that led to the destruction of many lives - whether it was overdose/death; losing child custody, marriages, homes, jobs; etc. The power of these drugs scared me.

On the morning of January 26, 2012, my personal life was transformed. My dog was run over by a truck in front of my house. I ran to the road to get her out of the road. As I scooped her up, she defended herself. She grabbed onto my left forearm and I tore free. She then latched her teeth onto my right index finger and I again tore free.

The results of this bizarre incident: 15 stitches to my left forearm (in Summersville); surgery to amputate my right finger tip and reduce/repair a dislocation (in Morgantown); and a legitimate need for pain medication following surgery. Surgery was performed on February 6 and on February 21 the bandages, cast, and dressings were removed. I was not at all prepared for what I would see of my right finger and hand - massive bruising and swelling plus the pin sticking out of my finger.

Pain medication reduces the pain and also makes me feel not unpleasant. On the morning of February 22 (back at home) I was feeling very unpleasant with what I'd seen of my finger though my finger wasn't in pain. My first inclination was to take the pain medication to make me feel not unpleasant. Then it hit me - this is how addiction begins. There's a difference between emotional and physical pain.

Fortunately I am aware of the potential devastating effects of addiction and that I was able to recognize the missing link. Pain medication is for physical pain, not emotional pain. I relayed my 'aha' moment to a friend of mine who is also a medical provider. When a person goes through significant personal trauma, there will be 'highs' with the novelty and when 'reality' sets in, an anti-depressant may be the non-addicting drug to bridge the gap."

.....

Ginger Day
McDowell County FACES / HOPE / Prevention Coalition

"Life expectancy is declining for both men and women in McDowell County, and while researchers determine obesity, diabetes and lung disease to be the cause, people who live in these communities add another factor: drug overdose deaths.

According to 2011 Kids Count survey, McDowell County ranked the lowest in the state in seven categories, including the highest number of children in poverty at 52 percent, the highest high school dropout rate at 23.6 percent, and 19.6 percent of McDowell County kids are "victims of abuse or neglect".

When you look at the reports and data you can't help but think the future is very disheartening. McDowell County Families Agencies Children Enhancing Services (F.A.C.E.S.) and Health Opportunities for Positive Education (H.O.P.E.) are working hard to change these statistics. FACES and HOPE have united with the Board of Education to take steps toward strengthening after-school programs and introducing evidence based programs such as: Keep A Clear Mind. (KACM) is a take-home drug education program for upper-elementary-school students (8 to 12 years old) and their parents. KACM lessons are based on a social skills training model and designed to help children develop specific skills to refuse and avoid the use of "gateway" drugs. This unique, early intervention program has been shown to reduce risk factors for later substance use. Two hundred and eighty students and parents/caregivers participated in this program and demonstrated 40 percent increase in communication.

F.A.C.E.S. was a key component in the planning meetings for McDowell County Day at the Legislature 2012. One agenda item discussed: the need for a County owned and operated treatment facility with a Suboxone Program. A certified substance abuse counselor on staff is instrumental in combating this issue. Communities in McDowell County cannot continue to struggle with the complex problem of drug addiction and be expected to make changes with simple solutions."

.....

Joanne M. Boileau
Children's Home Society of WV
Mercer County

"The Children's Home Society in Princeton provides a variety of services to children and families in Mercer and surrounding counties from adoption and foster care, to play therapy, to supervised visitation and exchange services, to WE CAN mentoring, and parent education for divorcing parents. There are families across all of these services that have struggled with prescription drug issues. In the most severe instances, children have been removed from families that are unable to keep their children safe while they battle their Rx drug addictions. An infant and his 6 year old brother were recently placed in a CHS foster home because the mom was improperly dosing the infant with methadone which was prescribed to him because of drug withdrawal symptoms at birth. The infant's withdrawal is obviously a result of the mother's abuse of drugs, including Rx drugs not prescribed to her. Generally when children are removed from their home due to the parent's drug issues, it takes 2 to 3 years for that child to be reunited with their parent, or to be free to be adopted. During this time the child has no sense of permanency, of how to effectively project their future, and who their forever family will be.

It is not unusual for one or both of the parents referred to our supervised visitation and exchange program by the Family Court to be involved or have a history of Rx drug abuse. One of the most devastating aspects of this plight is the relapse rate and the day to day struggle to stay drug free. Jennifer is a Mom who has visited with her children, brothers, age 10 and 12, at our Visitation Center on and off again for the past 3 years. This past year she gave birth to a baby girl, who was born addicted and was removed from her care, and it is not likely that she will regain custody of her little girl. Her track record for not completing drug treatment programs and for relapsing into the fog of addiction does not provide much hope for her being a mom to any of her children. Another family served by our visitation program has witnessed at least 3 drug overdose deaths, 2 mothers and a step-dad. These fatalities and all too often outcomes of Rx drug abuse are tragic on so many levels. Grandparents are forced into the role of parents, children become displaced and lose contact with family and friends, trust and love and other elements of strong relationships and bonds are eroded which can lead the child down their own path to drug abuse."

.....

Kathy Brunty
Wyoming County Family Resource Network

"The Wyoming County Prevention Coalition was organized in 2006 as our Substance Abuse Coalition. The members have grown in the past two years from six to as many as 38 attending the monthly coalition meetings. Supportive members include: youth, parents, state delegates, teachers, WVU Extension, SADD Coordinator, Family Resource Network, pastors, law enforcement, Board of Education, social service providers, and many more. This group has partnered with law enforcement to hold two Rx Take Back Days with the last endeavor collecting 130lbs of drugs. The Coalition accomplishments include: County Drug Forum, Town Hall meeting for Underage Drinking, formation of five SADD groups, SADD Rookie of the Year Award, six students complete Notional Youth Leadership Initiative, members attending 16 trainings on substance abuse prevention, providing workshops within their county, speciol events such as Drug Free All Stars, and monthly visits to schools in Wyoming County to provide support to SADD groups forming. Over 500 youth have signed up for SADD in 2011. One of our greatest partners in our Prevention Coalition is to our faith-based services. One Voice of Wyoming County has served our communities for over six years with no state or federal funding, yet maintains an office with three full time, volunteer staff to help families and addicts. They conduct outreach progroms such as: feeding the children with take home bags of food for the weekend, 12 step classes, job and resume support, packing lunches for o recovering addict when he got cleon and went to a job, plus over 10000 volunteer hours. One Voice is the connection to 221 churches in Wyoming County and our rural communities.

One special story: Jacob Snuffer joined our Coalition student group to become a member of the National Youth Leadership Initiative. Jacob is not a youth that really fits into the "sports star or popular click". Jocob came to us with great leadership potential, highly intelligent, but needed guidance and support as his older brother wos struggling with addiction. Jacob went from that kid setting on the sidelines to speaking before Congressmen Rahall, faithfully supporting SADD and his Prevention Coalition, ond assisting his group in becoming Rookie of the Year. Jacob submitted his story about his hometown and what needed to be changed to Community Anti Drug Coalition of America. He was honored by CADCA and is featured in their Annual Report for 2011. Jacob says becoming a part of the NYLI and SADD has kept him from following the crowd and standing up for what he believes in. Jacob is that one "Starfish" of many more to come in Wyoming County with the support of prevention programs."

.....

Anonymous
Mercer County

"Hello... I am an addict. I have a little more than three years of 'clean time' by the grace of God and the resources I have been given. I spent years in active addiction even while being a mother, daughter, sister as well as a nurse for 33 years. I finally became willing to reach out far help when I had exhausted all financial and other resources and was humbled enough to be receptive to that help. When I was finally ready, the help was there for me through the 12 step programs, the God of my understanding and the people who were there to help me.

I had never experienced a compulsian as strong as my addiction to narcotics. As a nurse I thought I had skills and could manage the use of these medications for myself. I proved time after time that I could not handle my use of opiates. I would swear not to abuse the medication but each time I got the pills, I took as many as I could, as fast as I could until they were gone. Then, the feot ond panic set in of what would I do now because everything in my brain told me that I could not live without opiates. I thought only a crazy person would repeat the same behaviors over and over and expect different results.

I was completely sincere each time I swore that I could 'wean down' but it was beyond my ability to do so without help. I'm grateful today that I was allowed to find help when I was finally willing to accept it. You don't see too many addicts over 50 years old, the just don't live thot long. There are too many options now that are incredibly lethal for those with o 'broken brain'. The last think we need in our society is another long acting narcotic prescription for sick people to use.

Addiction is not a character defect. Toward the end of my use, I had to take pills so that I would not be sick. I didn't want to take them, I actually used pills against my own will. But, I continued to use because I had no choice. Today, I have a choice and for that miracle I am deeply grateful.

As a nurse and a recovering addict, I see people die every day from this disease. Tragically, and pointlessly, lives are lost. Mothers, fathers, daughters, sons. Human beings lost forever!

Treatment is complicated and there is no magic bullet for this disease but we do have resources and those resources must be used in every way possible. Addiction is a cruel and vicious disease and has no intention but to take lives. We cannot sit by and watch it continue to grow out of control. We must do everything we can to fight this epidemic."

.....

Shannon Atwell
ChildLaw Services, Inc. – Mercer County

"ChildLaw Services, Inc. works to "balance the scales of justice" for children. Simply put, we are a law firm for children. Each year, ChildLaw provides a voice for more than 650 children who are abused or neglected, the subjects of high-conflict custody cases, who are victims of crime, and others who are involved in the legal system. Substance abuse is overwhelmingly the number one issue involved in our caseload. At least 95% of all cases (circuit court and family court) involve substance abuse by at least one party to the case.

Prescription drug abuse (narcotics and opiates) is rampant in the lives of those individuals caring for these children. ChildLaw attorneys represent children of all ages in Mercer County and southern West Virginia: from the drug-addicted newborn in the hospital to the adolescent and teenage clients whose families have been torn apart due to substance abuse.

For example...

'Justin' was first referred to ChildLaw Services due to a custody dispute between his parents in 2007. Justin, age 15, was unhappy with the custody arrangements and did not want to continue visiting his mother and stepfather. When the Court ordered Justin to visit his mother, Justin confided to his ChildLaw attorney that his stepfather had been sexually obusing him for numerous years. At that time, the attorney moved to stop immediate visitation and then reported the abuse to Child Protective Services (younger step-siblings were in the home) and law enforcement. Justin's mother, a drug addict herself, was not able to recognize the issues, nor could she protect her son. For months, the attorney spent hours on the phone and in person preparing Justin for court and the difficult task of testifying. They also arranged follow-up victim's services for Justin and his fother.

At this time, Justin receives ongoing mental health services as he tries to heal and move on with his life. The attorney represented him in Family Court during the custody dispute, then in the abuse & neglect proceedings and was with Justin as he faced his abuser in criminal court. Although it was a difficult time, the agency was able to work with him through this situation.

Prescription drug abuse not only affects the user, it affects those that cannot protect themselves. This past Thanksgiving, ChildLaw's Legal Director spent hours in the hospital nursery holding and rocking a drug-addicted newborn. Since the hospital staff is not able to provide the type of comfort a 'drug baby' constantly needs, such as swaddling, volunteers often serve as surrogates to help calm and nurture the child. Not surprisingly, within hours, the mother was nowhere to be found.

ChildLaw not only hears these stories regularly, but we see with these issues daily. So much needs to be done in terms the prevention and treatment of this epidemic and we cannot wait much longer. We already have a generational system of addicts in our system and we cannot afford to let our 'children of tomorrow' suffer an even greater fate.

.....

Stephen E. Dickerson, MS
Mercer County

"My name is Stephen Dickerson, and I have been in long term recovery from substance abuse addiction for nearly 12 years (March 16, 2000) and I am writing you this letter on behalf of myself, and many other citizens of the great state of West Virginia, to express the need for funding for substance abuse treatment facilities in our Great State.

We often associate the drug addict as being the skid row derelict that has lived a life of crime, in and out of hospitals, almost undoubtedly never to find his way. I'm letting you know that is not the average addict. I myself began a process of recovery with a meager 16 cents in my pocket; I had two changes of clothes, and even less friends. I had blazed a path of despair and destruction, hurting anyone who had the misfortune of caring anything about me. That was then! Because I was afforded an opportunity to obtain treatment, I was enabled to begin a process of healing. I was able to look inside of myself, and find the good person that lived within.

Today I live a happy life. I have a wife, two children, and a pretty decent golf game. I'm president of my local Shrine Club, where I work diligently, in my leisure time, to raise funding to transport children to the Children's Hospital in Kentucky. I volunteer on many local community levels, and I'm always willing to reach a hand out to help someone in need. I've shared my story as the 2009 WV Delegate for the A&E Recovery Project, where 11,000 of us walked Penn's Landing in Philadelphia to let the country know recovery happens. I flew to Tampa a couple years ago to participate in a training video for CADCA on connecting recovery, treatment, and prevention groups to fight this epidemic holistically. My story, as well as many others was highlighted in SAMSHA's Nation Recovery Toolkit.

My point is this: recovery happens! However, every day we have individuals literally dying while waiting on a bed to enter a treatment center. Not every addict wants to be in the position they are in; most don't know how they ended up where they are. We see people turned away every day, to go back to doing what they were doing. I'm telling you this: there is no other difference between myself and them, other than the fact that I was afforded the opportunity for treatment and I listened when I got there."

.....

Lori
Mercer County

"My name is Lori and I am a recovering addict. I will have 4 years clean this month. I was a nurse for over 20 years and after treatment at a pain clinic for migraines found myself addicted to opiates. After the first pill I thought I had found heaven, but in reality I was in a living Hell.

My addiction took me to places I never thought I would go. My addiction made me do things I thought I would never do. I could not stop. I lived this way for 12 years. At the end my career was lost. My family could not understand. I lost everything that mattered to me and still had to have the drugs.

I was found in my apartment not breathing and was rushed to the hospital. That was my bottom. I went to a treatment center for 21 days. When I was released I started going to a 12 step fellowship and met people who found a way out of that way of life and they shared it with me. I realize today that a have a disease, I am not a bad person, I am a sick person.

There are options for addicts. Jail and punishment did not work for me. I needed and still do need treatment for my disease. Treatment is so important. Treatment is very limited in Mercer County and our rate of Rx addiction is very high. I believe there are answers. We need more resources and treatment options if we are going to address this problem.

We need laws in place that follow doctors prescribing these very dangerous, very addictive drugs, laws that will help keep these drugs from being misused and sold on the street. There are solutions and I am very grateful that I found mine."

West Virginia State Police
725 Jefferson Road
South Charleston, West Virginia 25309-1698
Executive Office

Earl Ray Tomblin
Governor

Colonel C. R. "Jay" Smithers
Superintendent

March 9, 2012

I am Captain Timothy D. Bradley and I am in my twentieth year with the West Virginia State Police. The majority of my career has involved drug work both while in uniform and in an undercover capacity. For the last five years I was the Officer in Charge of the Bureau of Criminal Investigations which contains the undercover operations of the West Virginia State Police. Presently I am the Deputy Chief of Field Services responsible for all of the uniformed members of the West Virginia State Police and the undercover narcotics officers.

The new problem facing law enforcement is the abuse of legal prescriptions and legal substances for illegal gain. Prescription diversion creates a never before seen situation because the product is a legal substance which is initially legally distributed by our doctors and pharmacists. Often legal prescriptions lead to addiction problems that do not carry the social stigma associated with all other drug abuse. An example I use is when I played high school football one of my team mates was caught with marijuana. Because drug use brought with it negative connotations, we did not want drugs associated with our team. Through peer pressure we made sure that drugs were not linked with that or any other football player on our team. Today I see prominent high school students and athletes diverting prescription pills. This practice is not frowned upon and is appallingly socially acceptable leading others to imitate that behavior. Such abuse of prescription pills creates a devastating addiction problem that adversely affects good productive citizens.

Prescription drug abuse has become an epidemic in the State of West Virginia. In some counties, it could be better described as a plague. From 2001 to 2009 approximately 3,000 individuals died due to toxic accidental drug poisonings. These numbers do not include DUI related deaths involving prescription drugs. The majority of these deaths involved prescription drugs. Drug poisoning is the leading cause of death in West Virginians between the ages of 20 to 50 and we have the highest per capita rate of drug overdose deaths in the nation. Prescription drugs are now the most popular drugs being introduced in our middle schools. Unfortunately that is not the youngest population being affected by the illegal use of prescription drugs. Currently, it is estimated that approximately 20% of infants born in West Virginia are born with exposure to, or are chemically dependent on drugs. Some hospitals in Southern West Virginia have

reported infant exposure numbers as high as 30-50%. Prescription Opiates are the most common type of drug abused and account for the majority of infant exposures.

Prescription drug abuse does not discriminate; it crosses all boundaries of life without regard to race or socio-economic status. In many communities around the state, prescription drugs have become a common item of barter and are freely traded for property, cash and sex. Sadly, it is the family that is affected the most. When loved ones become addicted, children are left without parents, the elderly are left without their care givers and a family can be torn apart by the crimes of the addicted. Approximately 90% of the crimes that we investigate involve drugs and the majority of the drugs are prescription drugs diverted for illegal use. One 80 mg OxyContin tablet can be sold for more than one hundred dollars and often drug users will consume multiple tablets on a daily basis. On occasion one OxyContin tablet has been purchased for as much as $160.00. Abuse of prescription drugs becomes expensive and can lead the user to commit property crimes including burglaries or other larcenies in order to obtain money to purchase more pills. An involvement in property crimes may then lead to participation in violent crimes.

The West Virginia State Police has attempted to focus on the criminal enterprises that provide prescription drugs for monetary gain. These are commonly called pill mills because it is an assembly line type of operation where people go with complaints of pain and without a strong medical workup are provided with a prescription for pain pills. We have been able to work with federal agencies to close down several pill mills around the state and arrest numerous drug dealers from within West Virginia and from other states. The object is to decrease the availability of the drugs. Due to the fact that such an enterprise will cater to both addicts and to individuals with actual pain and the need for valid prescriptions, these investigations require extremely detailed analysis in order to secure convictions and close the pill mill. Such a time consuming examination means that the criminal enterprise is ongoing and more people are becoming addicted while the investigation is being completed. Suspected pill mills are specifically set up to function on the edge of legality. Although we are making headway here in West Virginia, this is becoming a national problem and we are seeing large numbers of individuals carpooling to other states or taking flights for the specific purpose of obtaining prescription pain killers.

In the past, law enforcement has been able to somewhat dismantle traditional drug trafficking organizations by working their way up the ladder through the suppliers. It is completely different with prescription drugs because after the first or second tier the next level is a health care facility or pain clinic that is operating on the edge of the law, has the required license to prescribe and supply narcotics. Legislation has not been able to keep up with the changing drug trends as clinics pump out hundreds of thousands of units of controlled prescription medications without violating the current law. Licensing boards have also become ineffective in policing providers. Under current law, if a drug seeker adequately represents that they have pain, the physician can prescribe legal pain medications without consequence. This makes it extremely easy for a pill mill to run a cash only business prescribing opiates to hundreds of individuals a day, keeping the now addicted patients on the same drugs for years while making enormous amounts of money for the proprietors of these clinics. Prescriptions are also being filled with very little scrutiny from pharmacists and many are under the mind set that if the prescription was issued by a licensed doctor then they have an obligation to fill that prescription.

Often a geographical area's drug choice and exposure is directly related to drug availability. This is what we believe occurred in this state. Individuals were introduced to prescription drugs such as hydrocodone by their local physician for actual pain management, the patient either used the drugs or left them in home medicine cabinets where they were used for illicit purposes. This exposure and availability lead to increased use and tolerance. This causes traditional drug dealers to capitalize on the increasing demand. Currently we are seeing a significant amount of prescription drugs such as Oxycodone and Oxymorphone being supplied from traditional drug trading organizations from source cities such as Columbus and Detroit which were originally obtained from a healthcare provider. Currently, the most available drugs are marijuana and hydrocodone. The most sought after drugs are Opana (Oxymorphone) and OC OxyContin (Oxycodone). The ability to circumvent the time release component of the compound allows addicts to receive an instant dosage of the drug. These drugs are also able to be snorted, smoked or injected, further increasing the speed with which the drug is received by the brain causing a euphoric high.

Should you have further questions or concerns, please feel free to contact me.

Sincerely,

Capt. T.D. Bradley

Captain T.D. Bradley
Deputy Chief of Field Services

Prepared Statement of Kimberly Becher, MD; and Kane Maiers, MD, Paul Ambrose Health Policy Fellows, Marshall University Department of Family and Community Health

Drug abuse in Southern West Virginia has an effect on our daily practice of medicine. As family medicine residents we are not only exposed to drug-seeking behavior, but see the long term effects of drug abuse in our patient population. Because we are new providers in the community, our continuity clinics are targeted by patients requesting controlled substances for recreational use. These visits not only take away slots in which we could be treating legitimate medical problems, they frustrate us as providers. We chose to be family physicians because we have a genuine desire to improve the health outcomes of our communities and we sincerely value the physician-patient relationship. We work hard to develop rapport and do not like to disappoint our patients. Despite the level of compassion and professionalism displayed as we deny unreasonable requests for pain medication, many visits with drug-seeking patients end with aggression, anger, and occasional threats of violence toward the provider. On more than one occasion a patient has revealed a weapon in our office.

Unfortunately, the most difficult of cases involve patients with progressive chronic disease that is unable to be properly addressed due to the patient's fixation on obtaining opiates or benzodiazepines. These patients emotionally drain us as providers. We spend the most time on these visits and make the least progress in decreasing the patient's morbidity and mortality despite our attempts at intervention. This patient population contributes a disproportionate amount to the cost of health care in West Virginia. This is not only limited to emergency room visits but also to the complications of untreated comorbid conditions that require hospitalization for a population that is largely uninsured or receiving Medicaid. The addiction circle is not limited to the patients we see in the office. To the unemployed, obtaining a thirty-day prescription for oxycodone will more than adequately pay their bills. One resident reports admitting at least one patient to the ICU per night who overdosed on prescription drugs they were not prescribed.

We need help combating this epidemic in Southern West Virginia. We need a national controlled substance monitoring program that is real time. Patients routinely fill prescriptions in Kentucky and Ohio, but we have also had trouble with more organized patients travelling to pharmacies in Florida. We need educational opportunities that prepare us to properly address prescription drug-seeking behaviors from the first day of practice. There is no grace period here. For many of us, our first patient encounter was a test of our ability to deny an unwarranted prescription.

Thank you for championing the development of legislation to curb prescription drug abuse.